The Impact of Corporate versus Professional Control Mechanisms on the Adoption of Health Informatics in Australia

By

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Mary Paulette Kelly
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Abstract

This study is grounded in a desire to describe and understand the positioning of eHealth within the health policy process. Policies and politics are intertwined (Corbitt, 1995). The current literature on health policy analysis suggested the problem of how to conceptualize power and relate power to notions like discourse and how to integrate these ideas of power into a conceptual framework for policy analysis. The current literature on power and politics in Information Systems (IS) deployments have drawn on limited conceptual resources to understand IS as artifacts, and power as a definable (and often manageable) entity, in ascribing IS a political role. This thesis questions the power relations that constitute the health policy process and those that are constituted by the health policy process. The research interprets health policy initiatives within the broader political and ideological context in which it is occurring. This study focuses on the discursive nature of health policy, and how various practices and techniques are implicated in governing the interpretation of policy intentions and behaviors to act in relation to policy. Of particular interest in this study are the discursive spaces for action within which acts of power and resistance can unfold.

This study aims to illustrate that the critical interpretive perspective (Doolin and McLeod 2005) applied to an understanding of health policy as a process constituent of power relations, a process involved in governance and advocacy tied to polity, knowledge and intervention can contribute to an understanding of the mobilization of authority and the impact this has on interpretation of policy intentions. This thesis argues that policy contexts create new discursive spaces for action, spaces which provide opportunities to maneuver allowing for framing of issues or resisting practice change. It suggests that the political landscape of action is made apparent within these spaces, and further that information systems become the medium through which the legitimacy of professional and corporate control mechanisms are contested. This thesis argues that renegotiated health information systems illuminate the reform ideas which have diffused into practice and those that have been delayed at a point in time.
Chapter 1

The systemization of information in the Australian healthcare setting

1.1 Introduction: The Adoption of Health Information Systems in Australia

This thesis is an analysis of the systemization of information as a means of diffusing reform ideas into practice in the Australian healthcare setting. This thesis attempts to respond to the question ‘Why has adoption of health information systems failed in Australia?’ Taken from the perspective that policy analysis needs to address the complexities involved in translating policies to practice, this study will develop understandings of information system adoption behavior on policy outcomes, and the impact of policy intentions on information systems adoption decisions. The study will be concerned with describing and analyzing the critical events in health policy history in which the systemization of information plays a key role.

1.2 Reforming Healthcare

Australia has a recent history with respect to the goal of a centrally organized, publicly administered health insurance system. This ambition for healthcare was not recognized, or supported, in Australia’s constitution (Hancock 2002:53). Creating an understanding of the need for a national approach to determining the direction of healthcare has formed the basis of health policy in Australia (Gillespie 1991, Willis 1989, Lewis 2003).

The dominance of the biomedical model of healthcare – a model based on a cultural belief that all disease results from cellular abnormalities (Wade and Halligan 2004:1399) – has guided the allocation of resources in healthcare. Substantial regulation provides the medical profession with their monopoly position as the principle healthcare providers in Australia, including registration which is a state sponsored license to practice and a means for regulating the supply of professionals (Deighton-Smith, Harris, and Pearson, 2001). In exchange for this monopoly the medical profession acts on the government’s behalf as gatekeeper to health services through the restriction of access to specialists via the referral process. The medical profession has been in a
position to exercise significant power because of ‘its special knowledge and authority, its particular form of organization, its legally granted occupational monopoly, its position at the top of the occupational hierarchy in health, its autonomy and its wider cultural authority regarding what constitutes health and illness’ (Lewis, 2006:2135). The dominant position of this model has relied on the shifting terrain of government interests (Palmer and Short 2010:366, Hancock 2002, Coburn 1993). Australia’s constitutionally supported private enterprise model for provision of healthcare has restricted government to influencing and not controlling changes which policy interventions seek to bring about in state-profession relationships: most health care policy-making is contained by consensus and managed within a corporatist-style, institutionalized relationship between the state and the medical profession (DeVoe and Short 2003:345, Lewis 2003, Gillespie 1991). Mutual interdependence has defined the Australian healthcare environment, emphasizing the importance of the means by which the interests of doctors and patients are shaped: ‘despite the prerogatives now attributed to clinician managers, medicine remains an occupation that has legislative and ideological backing for the monopoly power it exercises over its niches in the labour market’ (Degeling, Sage, Kennedy, Perkins and Zhang 1999:184).

Early forays by the Australian Commonwealth Government to influence the healthcare model and ascribe a greater role for the public health agenda resulted in a negotiated position in which the necessity of a two systems approach to delivering healthcare has been accepted (Gillespie 1991, Lewis 2003). The two system approach represented a stop gap solution to healthcare which has shaped the context of health services so that broadly speaking preventive medicine has existed in the sphere of public health, and curative medicine fell within the jurisdiction of a private fee-for-service model (Gillespie 1991, Lewis 2003). Healthcare reforms in the 1970’s introduced a publicly administered health insurance system focused on providing equitable access to hospital care, further entrenching the biomedical curative model of healthcare (Sax 1984, Scotton and MacDonald 1993). While the notion of biomedical healthcare as a right of citizenship has proved popular: ‘There is no doubt a perception in the electorate on each occasion (of attempted reform) that many people would be made worse off by major departures from the principles of universal healthcare coverage at low or zero costs to the patient, and the associated government controls’ (Palmer and Short, 2010:366), political support for the scheme

The adoption of a National Competition Policy (NCP) in the mid 1990’s (Banks 2008), which formally marked Australia’s migration from a welfare state to a market economy (Hancock 2002), describes a role for government in support of competitive structures in the provision of social goods, extended to challenging anti competitive behaviour in healthcare (Productivity Commission, 2005a). It has provided the means by which the government, as manager of the economy, can influence practice (Considine 1994). The introduction of publicly subsidized private health insurance (1998) has allowed for an influx of private interests drawing on public funds (Hurley, Vaithianathan, Crossley, and Cobb-Clark 2002), suggesting the management complexity of current arrangements.

Renewed activity in the area of health reform since the NCP has culminated more recently in the National Health and Hospital Reform Commission (NHHRC, 2009) report (Department of Health and Ageing (DoHA) 2009) which seeks to influence the governance of healthcare by promoting a preventative self management agenda that can be managed by market mechanisms. Restructuring efforts articulated in the NHHRC report focus on the demand side - the broader community is being asked to accept greater personal responsibility for life style choices with preventative health being emphasized: ‘the fundamental redesign of the health system based on embedding prevention by driving a paradigm shift in how Australians think and act about health and keeping well’ has been recommended (NHHRC, Executive Summary, 2009:5). On the supply side the medical profession is under pressure to change practices away from expensive consultations and interventions towards practices which emphasize individual responsibility for health, and ‘tackle practice inefficiency, waste through duplication and poor processes’ (NHHRC, 2009:53). A role for the Commonwealth Government in directing individual management of health is being sought, a role which eHealth will support but which sits uncomfortably alongside the existing institutional arrangements (Braithwaite, Westbrook, Iedema 2007).
Concern with over servicing, over utilization, effectiveness and information asymmetry in healthcare did not arise in the 1990’s, these discussions have had a place in the national health policy debate since the formation of the Commonwealth Government Department of Health (1921) and are described in Chapter 4 of this study. Indeed, without such concerns the legitimacy of government involvement in healthcare could be questioned. Distinguishing the current reforms dealing with the management complexity of healthcare, and described in the NHHRC (2009) report, are the possibilities offered by information technology in systemizing information to impact the behaviour of doctors and patients (DoHA 2009). The potential of information technology to diffuse reform ideas was recognized in the Broadband Services Expert Group (BSEG) Report (1995) which rejected a purely ‘hardware’ or technology-driven approach to information systems, emphasizing instead the content and cultural dimensions:

Australia can develop a competitive advantage in services and applications…. but only if we provide the right environment and encouragement to build expertise in applications while networks roll out. We need to have content to develop services, as well as to reinforce our cultural values.

(BSEG, 1995:viii).

The current (1997 to 2011) reform focus reemphasizes the need for policies towards information systems in support of Australia’s future economic growth, advocating investment in the information communications technology (ICT) sector, with the aim of developing a local ICT production sector through partnerships between government and the ICT sector (National Digital Economy Strategy 2011). The launch of the National Digital Economy Strategy in May 2011 describes the Commonwealth Government’s vision for the national broadband network as an enabler for eHealth in bringing about a transformation in healthcare (Department of Broadband, Communications and Digital Economy 2011). Framed within Australia’s digital economy, the concept of eHealth has the support of State and Commonwealth Governments (Australian Health Ministers’ Conference 2008).
1.2.1 The promise and potential of eHealth

Haux (2006:269) refers to Health Information Systems as complexes or systems of processing data, information and knowledge in healthcare environments which have followed a developmental trajectory of: ‘(1) the shift from paper-based to computer-based processing and storage, as well as the increase of data in health care settings; (2) the shift from institution-centered departmental and, later, hospital information systems towards regional and global IS; (3) the inclusion of patients and health consumers as HIS users, besides health care professionals and administrators; (4) the use of HIS data not only for patient care and administrative purposes, but also for health care planning as well as clinical and epidemiological research; (5) the shift from focusing mainly on technical IS problems to those of change management as well as of strategic information management; (6) the shift from mainly alpha-numeric data in HIS to images and now also to data on the molecular level; (7) the steady increase of new technologies to be included, now starting to include ubiquitous computing environments and sensor-based technologies for health monitoring’. The emphasis Haux (2006) places on change management and ways of thinking about healthcare as patient centric, concentrating on regional/global healthcare planning with a focus on disease and population health, resonates in the Australian context. Eysenbach (2001:e20) takes a similar view to the significant change management role while providing a more succinct description, suggesting eHealth as an umbrella term that incorporates Health Information Systems in the delivery of health services and as accessible via the internet: ‘e-health is an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology.’ (Eysenbach, 2001). The emergent nature of the field is reflected in policy documents and academic literature which refer to Health Informatics, Health Information Systems and eHealth to describe the change management role. Throughout this thesis the use of these terms are used interchangeably in line with the common usage.
eHealth has had a long incubation period in Australia. The Health On Line report was first tabled in parliament in 1998, marking the initiation of a national electronic health record (EHR) system (Showell 2011):

With shifts in emphasis in the health care system to health outcomes, the interests of public health and individual health care converge. This view is gaining acceptance amongst State governments who support the concept of evidence based medicine and the strategic use of Health Informatics as essential to new ways of delivering health care and enabling the measurement of clinical outcomes.

The intention to merge public health principles of population healthcare into a private practice model, diffusing these ideas into practice through informatics was articulated in the Health On Line Report (1998). The direction of eHealth strategies as inclusive of health delivery mechanisms, and economic opportunities, was first summarized by the ‘Towards an Australian Strategy for the Information Economy’ commissioned by the Ministerial Council for the Information Economy, July 1998 (cited Swanson 1999). The last decade has seen constant activity in the eHealth space, demonstrating mixed results. Telemedicine, which uses Information Communications Technology to provide specialist consultation to distant communities, is well developed in Australia (Michell 1998). Telehealth, which incorporates wider health goals of self management and patient education, is less developed (Celler and Lovell, 2003). HealthConnect, an eHealth initiative, pursued the implementation of Electronic Health Records with limited success (Showell 2011), eventually HealthConnect was recast as a ‘change management strategy’ (Abbott 2005b). The establishment of the foundations for eHealth was transferred to the National eHealth Transition Authority in July 2005 (DoHA 2005). The Healthcare Identifiers Act (2010) was passed in June 2010 (DoHA 2011b) preceding the scheduled introduction of a personally controlled electronic health record due in July 2012 (Dearne, 2011).

In spite of the perceived potential of information systems in healthcare delivery, administration and as a growth market, recent studies have raised concerns about the gap between the promise and the uptake of the technology in healthcare (Coiera 2011, Westbrook and Braithwaite 2010). Coiera (2007:s98) noted ‘Information technologies seem crucial to the development of
sustainable health services, but every IT intervention seems to generate an unanticipated consequence’. Coiera (2011) asked if a national electronic summary care record was justifiable for Australia, taking a cost and efficacy perspective, a question also posed by Greenhalgh (2010) in relation to the National Health Service in the United Kingdom. Westbrook and Braithwaite (2010:399) questioned the efficacy of technology facilitated collaborative team based approaches to healthcare: ‘Most of us think that it must be the case that there is a positive relationship between collaborative clinical networks and good patient outcomes. But there are problems’. A major gap between the promise and reality of eHealth in improving quality and safety in healthcare in a cost effective manner was identified by Black, Car, Pagliari, Anandan, Cresswell, Bokun, McKinstry, Proctor, Majeed, and Sheikh (2011), focusing on the experience in the United Kingdom.

The translation of policies into practice, particularly where information systems are involved, remains a challenge and a legitimate concern. Crucial questions about the role of information systems in enabling reform and the impact of power and politics on adoption behaviour are raised by Australia’s eHealth agenda.

1.3 Studying Health Policy

This study begins from the perspective that information systems’, or more accurately the practice of systemizing information, has had, and continues to have, a role in the policy process. It will be argued in this thesis that an investigation of information systems in the political landscape must involve itself with the pre-history, not only of the information system, but the history of ideas which shape the landscape. The focus will be on the management and control of the conceptualization of information within and between groups, with attention directed towards the political dimensions – the ‘act’ of systemizing information. Of concern is the micro-politics of power, what Foucault refers to as the capillary forms of power’s existence. Information systems researchers have focussed attention on the broader social implications of information technology, such as on national socio-economic development, work, privacy, identity, or democracy of information technology (Avgerou, Siemer, Bjorn-Andersen,1999). This thesis begins from a different starting point; the focus is on the shaping influence of the act of systemizing
information on the texture, pattern, organization and routines of everyday practices. In this way an improved understanding of the impact of policy and the tactics of power on health informatics adoption behaviour can be scrutinised.

Taken from this perspective this investigation of adoption of information systems in healthcare concerns itself with history and context, and attempts to make sense of the complexity of policy implementation. Based on the assumption that policy and politics are intertwined, a view of policy as beyond a simple rational construct is accepted. Supporting a view that policy analysis needs to address the complexities involved in translating policies to practice, this study seeks to develop some understanding of information system adoption behavior on policy outcomes, and the impact of policy intentions on information systems adoption decisions, through an analysis of the systematization of information in the Australian healthcare setting.

Despite policy analysis having explored different theoretical frameworks, health policy analysis, which is described as unique and with specific characteristics (Walt and Gilson 1994, Palmer and Short 2010), is limited in its use of theory, focussing its analysis of policy on ‘what happened’ to the neglect of ‘what explains what happened’ and constraining understanding of causality (Gilson and Raphaely 2008, Walt, Shiffman, Schneider, Murray, Brugha, and Gilson 2008:309). The notion of causality is suggested by Buse (2008:354) as contributing to the challenge of selecting appropriate theoretical frameworks in health policy analysis. Causality is said to explain ‘an outcome through a measurable variable that exists independently of any participant/observer’s understanding’ in the natural sciences (Buse 2008:354). Explanation of impact and effect of intended and unintended consequences in policy studies is associated with perceptions, values and beliefs of participants, and the observer of the variable, and is more amenable to interpretivist or critical approaches (Buse 2008, Klein and Marmor 2006). Coveney (2008:516) argues that health policy researchers and audiences in Australia value the epistemological demonstrations favoured by those schooled in empiricism, suggesting ‘a rigorous and defensible approach to policy analysis is needed for credible critique’ (Coveney 2008:516). This supports the noted dominance of health economic policy analysis and policy analysis of funding arrangements in Australia (Baume 1995 cited Coveney 2008:516). Coveney (2008), like Buse (2008), identify the audience for health policy analysis as sceptical of alternate
approaches to policy analysis. Criticism of the dismissal of the contribution of broader policy studies and policy analysis to health policy analysis in Australia, and suggestions that the myopic view of health policy analysis is unjustifiable has been voiced by Palmer and Short (2000, 2010).

This thesis will offer a conceptual framework for health policy analysis from a critical interpretativist perspective informed by debate and research undertaken in the broad policy studies community and specifically from studies within the Information Systems discipline which has recently focused on concepts of power and politics. Concepts of power and policy will be described to explain the complex process of translating policy into practice. The study will examine the health policy process as meaning making in some detail by focusing on the systemization of information and adoption behaviour, drawing on empirical evidence, during critical events in the policy history of health. The target of analysis isn’t institutions, theories or ideology, but practices (Foucault 1981:75). Practices are places where the rules are imposed on what can be said and done, where ‘the planned and taken-for granted interconnect’ (Foucault 1981:75). The aim becomes to write a policy analysis not of the implementation of information systems but of the practice of systemizing information. The concept of policy as discourse will be utilized to examine the transformation of the discursive formation of healthcare through the practice of systemizing information, a practice supporting the creation of expert knowledge. Emphasis will be placed on how policy problems are framed and solutions positioned. The intention is to illuminate the motivations of policies, clarifying the role of information systems in policy and practice, and allowing for an explanation of resistance to adoption

1.4 Rationale

The shaping influence of information and communications technology on the texture, pattern, organization and routines of everyday practices, has the potential to transform notions of healthcare. A shift from dependence on a biomedical model to alternate health models becomes possible. As such a renegotiated role for information systems may result in the reinforcement of existing institutional arrangements. The problem of how to conceptualize power and relate power to notions like discourse and how to integrate these ideas of power into a conceptual framework for policy analysis suggested the need for a conceptual framework which allows for
the exercise of power to be viewed as constituent in health practices. Despite critical research in IS having had as central the concept to power, there is limited evidence detailing the role of information systems in support of government reform efforts which seek to challenge established institutional structures. The lack of attention paid to power and politics by information systems researchers has been recognized as a weakness (Kling 1980, Markus 1983, Buchanan and Badham 1999) and has received renewed criticism (Zilber 2008, Land 2010). Yet, lively debate concerning the nature of power and the role of information systems in the exercise of power exists in the Information Systems discipline. The inability of information systems researchers to explain the failure to adopt information system in the Australian healthcare setting is limiting responses to issues and will influence the negotiated systems deployed. The potential of eHealth initiatives will be constrained as a result. The stakes involved in health information system implementations are high in terms of organizational risk and financial investment, and its perceived usefulness.

The search for market led solutions to social problems has fuelled the impression that the costs of a universal health system are unsustainable. If health information systems are the key to tackling equitable access to healthcare services placed increasingly in the hands of private enterprise, it is important that policy developers and policy implementers understand the consequences of what they are doing. It is equally important that they understand the history of ideas which are informing current reforms so they can recognize, interpret and plan for resistance strategies. Understanding the potential of information systems to transform the key relationships in healthcare and affect a political exchange will assist in managing expectations in the politicized health setting. This analysis of the systemization of information to diffuse reform ideas will, as a consequence of describing critical events, highlight the diffused practices which represent the history of ideas informing our understanding of the possibilities of information systems in healthcare. Renegotiated information systems will indicate the ideas that have been diffused into practice at a particular point in time. This will assist in developing an understanding of the constraints in which eHealth must operate, and developing strategies for acknowledging context and history in policy implementations involving information systems.
1.5 Research Question and Methodology

The research approach used in this study is consistent with a critical interpretivist methodological position (Putnam 1983, Doolin 1998). The underlying research question concerns the extent to which healthcare information systems are constituents of the management and market related discourses reproduced in the context of governmental reform. The research question raised is,

What are the impacts of corporate versus professional control mechanisms on the adoption of health informatics in Australia? This then raised the following related question, What is the impact of power and politics on the adoption of health informatics in Australia? and the following sub questions:

- How can power and politics be understood to operate through information systems?
- How can power and politics be understood to influence the translation of policies to practice?

Addressing these questions involves a genealogical analysis of the employment of the practice of systemizing information during periods of reform in healthcare. By examining the disputes which lead to the renegotiation of the information systems and the renegotiated information system, the researcher gains access to the wider institutional and external discourses (Ball and Wilson 2000, Doolin 2002).

This thesis examines the context and meaning of specific events within which health information systems have been deployed. This study aimed to achieve this by combining a local, situated study with a wider societal and historical perspective. A three-layer approach was adopted (Klecun, 2005:389) which placed local strategies (practitioners perspective – ‘mezzo layer’) and individual projects (‘micro layer’), under the umbrella of Australian health policy and broader national policy aims (‘macro layer’), focusing on critical events in the history of health policy in Australia: combining qualitative approaches with genealogical analysis. The genealogical analysis undertaken in this thesis followed the construction of two core ideas which have shaped the Australian healthcare setting: 1) healthcare is manageable, and 2) quality healthcare is deliverable through the ‘right’ practice. The study employed techniques such as documentation
review, social contact, unstructured and semi structured interviews. Adhering to the fundamental principles of a critical interpretivist approach to IS research, qualitative research was completed.

1.6 Limitations of the Study

This analysis of the systemization of information as a means of diffusing reform ideas into practice in the Australian healthcare setting has several limitations. The participants in this study were at times recollecting their involvement in past reforms. For some participants their recollections ranged from vivid to hazy. With the benefit of hindsight alternate interpretations of events have been made. In more recent reflections, participants were under the influence of their employing agencies and the values of those organizations. Not all influentials involved in affecting reform in Australia’s healthcare setting were interviewed. As a result a complete picture of the systemization of information as a means of diffusing reform ideas is not presented.

1.7 Outline of the Thesis

Chapter 2 begins with a literature review focusing on the systemization of information. In this chapter the relevance of social, political and economic context in understanding information system deployment is emphasized. The literature review is used to inform the analytical framework. A conceptual model is constructed which concentrates on understanding the practice of systematisation of information in healthcare, the tactics which underpin the taken-for-granted manageability of information in healthcare and its relationship to the history of ideas. This provides the interpretative framework in which the motivations and responses to information system are examined.

Chapter 3 explains the methodological framework. The methodology is described along with the method for analysing the data. The chapter includes a discussion of the interview process and the use of a critical interpretivist perspective in this study.
Chapter 4 describes the policies which were developed during critical events. These critical events include the establishment of a Commonwealth Government department of health, the attempts to nationalise medicine in the 1940’s, and the introduction of a universal health insurance system in the 1970’s. The policies preceded attempts to shape a market society, and represent ideas about how to shape the interests of patients and doctors. The social, political and economic environment which informed and facilitated reform attempts will be described. Emphasis is placed on the legitimacy granted to the role of the Commonwealth Government in setting the direction of healthcare. The renegotiated role of the information systems deployed during these critical events will be analysed to suggest the ideas which have been diffused into practice.

Chapter 5 interrogates the policy tools, and policy technology deployed in support of a new economic form which was shaping a market society during the 1990’s, and changed social values with respect to healthcare. As in the previous chapters, critical events which demonstrate the redefinition of the realm of central control in the management of healthcare, specifically in relation to the systemization of information, will highlight points of resistance and change. This chapter explores the environment which existed during the introduction of the Casemix Information System in the first half of the 1990’s, in order to gain a greater understanding of the role of systemization of information in political exchanges. As with the previous chapter, the focus is on the transformation of the discursive forms of healthcare. The chapter concludes by analyzing the set of rules which determine the discursive space in which healthcare operates following this period of reform. The impact of diffused practices on current reform efforts will be explored.

Chapter 6 describes the environment which existed during the introduction of the Health On Line report in the late 1990’s, in order to gain a greater understanding of the role of systemization of information in political exchanges. As with the previous two chapters, the focus is on the transformation of the discursive forms of healthcare. The chapter analyzes the set of rules which determine the discursive space in which health information systems operate. The impact of diffused practices on current reform efforts will be explored.
Chapter 7 synthesizes the results from each chapter. The discursive spaces for action which provide opportunities to maneuver allowing for framing of issues or resisting practice change are identified. Information systems as the medium through which the legitimacy of professional and corporate control mechanisms are contested will be reexamined. The concluding chapter includes a discussion of the usefulness and implications of the findings.
Chapter 2

Translating Policy to Practice: a Conceptual Framework

2.1 Introduction

This chapter establishes the conceptual framework for the study of the systemization of information as a means of diffusing reform ideas in the Australian health setting. With its focus on the problem of how to conceptualize power and relate power to notions like discourse and how to integrate these ideas of power into a conceptual framework for policy analysis, the potential of information systems in the practical management of social and political problems in healthcare, the political context, takes center stage. This chapter explores research and theory relating to power and politics in health policy studies and in information systems deployments in order to explain power relations as multilayered and present. The critique of the literature will identify gaps in light of other theoretical traditions, suggesting the conceptual resources required to develop a conceptual lens. The conceptual lens will provide the means through which the impact of power and politics on the adoption of health informatics in Australia can be viewed.

This study of the literature argues that understandings of power and politics in health policy studies have been inadequate to provide explanations of causation in examination of the unintended consequences of policy. Explanations of power and politics in information systems deployments have largely drawn on limited conceptual resources to understand IS as artifacts, and power as a definable (and often manageable) entity, in ascribing IS a political role. Despite having information and the systemization of information as a central concern, resistance to the act of systemizing information is not well represented in the literature. Yet, these issues continue to attract debate within the Information Systems research community. Conceptualizations of power in Information Systems, even those taking a critical approach, have tended to fall short of a conceptualization of power as relational and based in situated action. The relationship between resistance to the adoption of information systems and power is explored in this chapter as mutually interdependent. The basis of the argument in this chapter in which power, politics and resistance are recognised as central to information systems deployment and adoption suggests
resistance is not represented in the interaction between IS and user but in the ideas which led to IS being proposed as a potential solution to the problem of delivering social goods.

The chapter will begin with an informed analysis of the empirical literature detailing the role of information systems in health policy, followed by an analysis of health policy studies to inform the conceptual framework being proposed. The second section of this chapter will provide an analysis of the theoretical and empirical literature detailing the deployment of information systems which will identify weaknesses in approaches that are based on an overtly deterministic logic, a static conception of power and an unclear specification of the political context. In developing the conceptional framework, a body of health policy literature which is concerned with health policy as a political process will be analysed (2.3). Studies which have concentrated on understanding the nature of power and politics in Information Systems deployments provide the focus for the second part of this review (2.4). The challenge to translate policies into practice provides an alternate way of understanding the problem of acceptance of information systems in the political healthcare environment is described in 2.5. I argue that there are shortcomings in existing explanations of the power, politics and resistance in existing health policy research and Information Systems research which benefit from an expanded explanation of what is at stake (2.6). Finally, the conceptual lens which will inform the analytical framework is described in 2.7.

2.2 The Role of Information Systems in Health Policy

The transformative potential of information systems in healthcare in effecting more efficient resource allocation, directing individual management of health, and directing improvements in safety and quality of healthcare practices has been explored in a number of Australian policy related studies (Celler and Lovell 2003, Hordern, Georgiou, Whetton and Prgomet 2011, Harris, Williams, Dennis, Zwar and Davies 2008, Sco
derson 2002). Celler Lovell and Basilakis (2003) identified the potential of home telecare to manage and prevent chronic disease symptoms, calling for a long range government strategy. Hordern, Georgiou, Whetton and Prgomet (2011:6) outlined current evidence about consumer use of eHealth and describe a role for government in monitoring and control of the consumer eHealth setting. Extending the role of government in policy development to encouraging adoption and steering the right consumer
eHealth choices, Hordern, Georgiou, Whetton, and Prgomet, (2011:12) suggest ‘Policy measures need to ensure that consumers and service providers are discerning and critical in their use of eHealth services … Such policies should also highlight the necessity to educate consumers. Policy initiatives will need to provide a comprehensive framework, which will ensure that these broad-ranging consumer eHealth services can be effectively, efficiently, and safely accessed’. Harris, Williams, Dennis, Zwar and Davies (2008:s17) describe self-management support as ‘collaboratively helping patients and their families to acquire the knowledge, confidence and skills to manage their condition’. Harris, Williams, Dennis, Zwar and Davies (2008) describing the models of integrated primary healthcare being developed by governments calls for increased general practice funding and workforce availability, and suggests a role for government policy in encouraging adoption of new practices: ‘Self-management support needs to be seen as a key aspect of overall chronic disease management and an opportunity for GPs and other practice staff to engage in and promote better quality of care and health outcomes for their patients’. Scotton (2002:35/36) acknowledges a role for eHealth in the translation towards managed competition. Detailing the requirement for integrated systems in order to have a database capable of generating risk adjustment categories and relativities applied to the population, recording budget holder responsibilities and sharing utilization and cost data on the population, Scotton (2002:xiii) proposes policy initiatives that use financial incentives to modify the actions of funders, service providers and consumers to improve the efficiency of healthcare services. Placing the implementation of health information systems in the broader context of global political reform, Starr (2000:23) focusing on the United States health system, described the broader framework of the ‘new economy’ rooted in information technology, in which health informatics assumes a central reform role. Describing a reform agenda which elevates transparency, consumer choice and quality as guiding principles, and situated in a high growth context, health informatics become a response to a dynamic economy (Starr 2000:23).

Despite the perceived potential of health information systems, implementation difficulties have been encountered. Identifying limitations in socio-technical analysis to adequately explain IT failures in healthcare in the Netherlands, Berg, Aarts, van den Lei (2003:300) suggest ‘systems fail because they are built upon the wrong assumptions, they incorporate problematic models of medical work, or fail to see implementation as organizational change’. The socio technical
approach, which negates the impact of power and politics in the process of introducing change, focuses ‘on the way interactions between humans restrict or shape interactions between humans and technology... People’s behaviour is firstly shaped by the intrinsic social nature of the human animal ... and by the attitudes of others to these behaviours’ (Coiera 2007:s100). The social or cultural realm is understood to be willingly adhered to making resistance difficult to understand outside a simple explanation of resistance to change. The political potential of eHealth described by Starr (2000), Scotton (2002), Hordern, Georgiou, Whetton, and Prgomet (2011), and Harris, Williams, Dennis, Zwar and Davies (2008), describe the new ideas driving change. Resistance conceptualized as resistance to the ideas driving change provides an alternate explanation of the uncertain balance of eHealth successes and failures, and the perception that eHealth interventions have not delivered the value expected.

Klecun-Dabrowska (2002:6) argue that ‘the implications of technology cannot be removed from the understanding of the processes of conceptualizing, conceiving and using the technology’, calling for a broader perspective which encompassed national health policies and ideas of the information society. Klecun-Dabroska (2002:346) concludes that the ‘meanings telehealth acquires at first appear to be solely concordist, but further interpretations (readings) uncover more ambiguous meanings’. In later research, Klecun’s (2005:393) critical analysis of teleHealth in the UK focused on different rationalities underpinning teleHealth. Drawing on Habermas’s concept of the ‘ideal speech situation’, Klecun (2005:404) found that ‘teleHealth systems are not simple, relatively neutral tools: rather, they are complex systems with many biases. This is not acknowledged in policy and strategy papers, but it is experienced by those being affected by such systems’. The utility of a simple uncomplicated portrayal of health information systems was not the focus for Klecun-Dabrosak (2002) and Klecun (2005), despite recognizing the constraints of a managerialist interpretation, the focus was on the meaning telehealth acquired at policy. In Australia where the role of government in the delivery of healthcare is a site of contestation, a focus on the meaning of health policy to understand the ideas which influence the interpretation of information systems in healthcare is suggested.

Showell (2011) identified patient privacy, patient identification, and management of patient consent for use of information as health policy issues in Australia. Showell (2011:40) found
disagreement in the assumptions underlying the term ‘health consumer’ as bestowing a right to select and choose in a health marketplace. Citing Churchman (1967:B141), Showell (2011:44) describes Australia’s eHealth policy debate as having the characteristics of a ‘wicked problem’, ‘…social system problems which are ill-formulated, where the information is confusing, where there are many clients and decision makers with conflicting values, and where the ramifications in the whole system are thoroughly confusing’. This view of Australia’s eHealth experience was also expressed by Westbrook, Braithwaite, Georgiou, Ampt, Creswick, Coiera and Iedema (2007) who extended the conceptual dimensions of socio technical theory with the concept of wicked problems to investigate problems with the implementation and evaluation of eHealth at an Australian hospital – using a definition of wicked problems as: ‘Wicked problems are those that are ill-defined, ambiguous and associated with strong moral, political and professional issues. (Westbrook, Braithwaite, Georgiou, Ampt, Creswick, Coiera, and Iedema, (2007:747).

Focusing from an organizational perspective, and drawing attention to the impact of organizational issues on ICT integration and use, (Westbrook et al 2007:746) suggest ‘the need to appreciate health informatics as a wicked sociotechnical problem with no mechanistically deterministic resolution’.

The strong political and professional issues alluded to by Westbrook et al (2007) and Ludwick and Doucette (2009) are summarized by Degeling, Maxwell, Kennedy, Coyle (2003:650) as the healthcare ‘modernisation’ agenda within which ‘reforming how clinical work is organized, performed and monitored’ is placed near the top of the policy agenda in Australia, New Zealand and the United Kingdom. Degeling, Maxwell, Kennedy, Coyle (2003:650) suggest the differing professional cultures were recognized as introducing tension between management and the medical profession. Yetton and Johnston (2001:153) empirical study of health IT management focused on the professional and administrative support hierarchies of hospitals. They found competing forms of fit ‘Attempts to introduce general management principles and practice into health systems in Britain and Australia have largely involved the imposition of machine bureaucratic management solutions on the professional bureaucracy … through standardization, routinization, performance measure and tight budget control’ (Yetton and Johnston 2001:153). Yetton and Johnston (2001:155/6) suggest IT management was impacted by the conflict between powerful stakeholders with competing goals and priorities: ‘it seems apparent that the profession
will never accept a machine bureaucratic solution while the government on the other hand will continue to tightly control funding for public hospitals and refuse to allow a return to earlier levels of professional control of the health system’. Despite Yetton and Johnston’s (2001) pessimism, changes in the institutional structures supporting medical dominance have been influential. Scotton and MacDonald (1993:269) argue that the introduction of Medibank in the 1970’s replaced the corporate relationship which supported medical dominance with a political lobbying relationship between the profession and the government: ‘Before Medibank it was generally accepted by health administrators and politicians that the veto power of the profession constituted an absolute constraint on policy initiatives’. Willis (2006) suggests the period of medical dominance in Australia ended in the 1990’s impacted by neoliberalism and economic rationalism. This view was shared by Lewis and Marjoribanks (2003) who investigated the impact of reforms on professional autonomy of GP’s in Australia saw a reduction to both financial and clinical autonomy. Germov (2005:739/741) drew attention to the national variations in application of managerialism during the 1990’s, suggesting there are ‘significant national variations on the managerial trend’: describing the Australian context as ‘managerial reforms have been associated with increased levels of stress and work intensification among health professionals’. Willis (2006:428) refers to the ‘decline or stability’ debate within which the changing authority of the medical profession is framed, arguing that the debate can only be understood when placed in the wider societal and political economy driving health reform, Germov (2005) suggests placing the investigation within a national context.

Kemp (2007:43) sought to understand the phenomenon of medical dominance in Australia, Canada and the United States as institutional change of the delivery of medical care. Kemp (2007) acknowledges Starr’s (1982:4) description of medical dominance ‘The history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict over the emergence of new hierarchies of power and authority, new markets, and new conditions of belief and experience’, and places as central the role of knowledge, suggesting the ability to provide knowledge of the delivery of medical care, knowledge which can create a force for change (Kemp, 2007:48/50), will create a shift in medical dominance allowing for change in healthcare delivery systems. Kemp (2007) highlights the transforming potential of health information systems. Hancock (1997) also placed knowledge as central in discussing power
bases in Australian healthcare, referring to the crux of the debate as the contested and shifting power base of doctors and suggesting ‘integral to discussions about power in health policy are debates about the hegemony of medical power/knowledge’. Osborne (1993) in the United Kingdom and Hancock (1997) in Australia demonstrated new paradigms of power through budget control and managerialism. Osborne (1993:354/5) argues that reforms bring about an alignment of medicine with managerialism, programming medicine like a market. Beyond the reductionist clinical/control and clinical/management debate, Willis (2006), Hancock (1997) and Osborne (1993) suggest an understanding of information systems role in the reform agenda as redefining the power relationships of the key stakeholders.

The central role of power relationships in health information system adoption behaviour was demonstrated by Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou’s (2004:614) whose extensive literature review of innovation diffusion in healthcare organizations in the United Kingdom found that power relations were critical to successful implementation in complex healthcare organizations but were not examined in most empirical work in the adoption literature. There are exceptions, Denis, Hebert, Langley, Lozeau, and Trottier (2002) underlined the interests and power of actors in an adopting system in Canada as affecting their interpretation of the validity of information from information systems. Denis, Hebert, Langley, Lozeau, and Trottier (2002) suggest the neutrality of IS may not be accepted in all situations. Stoop, Bal and Berg (2007:s234) focused on the context and the interests of the stakeholders in the Netherlands health setting and found, like Westbrook et al (2007) in Australia, that it was not the quality of the ICT system that guaranteed success but more important was the congruence in stakeholder interests and the ‘moment in time’ in which the interests converged. The fragility of the interest alignment led to continuously changing incentives and constraints which both facilitated and threatened the success of the healthcare ICT implementation being investigated (Stoop, Bal and Berg, 2007:S234). Common amongst all of the studies is the indication that an accord between key stakeholders influences adoption behavior. The processes used to affect an accord, to steer the interests of physicians and patients, were not the focus of these studies.
2.3 Health Policy as a Political Process

As an area of public policy, health policy is inherently political (Buse 2008). Palmer and Short (2000:25, 2010) describe the nature of Australian health policy as subject to: 1) agenda setting and influence from the medical profession, 2) the monopolistic nature of the health system (Sax 1984) which requires modification of the free market approach informed by policy, and 3) the life and death nature of healthcare care decisions. Policy reforms often depend on political compromise and not on rational debate (Moran 2000), how issues get on the policy agenda and how they fare once there, and which solutions are offered, and rejected, suggest power structures are of particular interest in health policy analysis (Sax 1984). ‘Health care facilities in modern industrial societies are great concentrations of economic resources – and because of this they are also the subject of political struggle’ (Moran 1999:1). Despite this, health policy analysts continue to take a structuralist approach to health policy studies. Starke (2010:487/8) highlights the current concentration on ‘descriptive work – case studies and comparisons of health care systems – on the one hand, and evaluations of specific reform effects on the other’ and the reluctance to integrate explanatory approaches. Structuralist approaches have dominated health policy analysis from Dunn’s 1981 six general procedures to incorporate in analysis, Portney’s (1986) three approaches to policy analysis, and more recently Collin’s (2005) eight step framework for the analysis of health policy.

Etzioni (2006) and John (1998) argue that perception of sociology and the practical reality of political analysis where the range of confounding variables possible under the rubric of institutions, interests and ideas, which interact to create policy, embroils policy analysis in the social phenomenon it is trying to deal with. They point to the challenge of ‘doing’ health policy analysis as the objectivity of policy research and the need to expose ideas and interests. In practice, this challenge is unmet by health policy research which is often subject to grants from stakeholders in the policy process and ‘motivated by practical concerns such as the evaluation of existing programmes’ rather than challenging the institutional arrangements, while ‘the notion of power – fundamental to policy analysis – is a highly contested concept’ (Walt, Shiffman, Schneider, Murray, Brugha, and Gilson, 2008:310). Yet interest in examining health policy in ‘the broader context of market economies and democratic competitive politics’ has surfaced in
the United Kingdom (Moran 2000:136). Walt et al (2008) in their study of health policy in the United Kingdom suggest the challenge of ‘doing’ health policy to gain an understanding of causality and the impact of unintended consequences of policy is compounded by diverse understandings and concepts of policy and power.

2.3.1 Concepts of policy in healthcare policy analysis

Conceptualising health policy is complicated by what Osborne (1997:176) describes as the problem of health in policy – ‘health is a matter for government in so far as the health of the population is a concern of the state: yet, the provision of health is also related to the pursuit of truth – concerning the norms of population and the body – and, as such, should be a matter of indifference on the part of the government’. For Kant (1979) what the state must do is avoid dictating the norms of health, rather it should regulate the production of truth by governing not health itself by those who are delegated to speak in the name of health, the medical profession. Treading this fine line is the suggested aim of health policy, positioning health policy as a process involved in governance and advocacy tied to polity, knowledge and intervention.

Policy as a process and a point of advocacy is considered of critical importance in healthcare (Ryder 1996) where a number of governing structures – including professionalism, corporatism and the market – are at play (Alford 1975). Alford (1975:262), whose situated analysis (Checkland, Harrison, and Coleman, 2009) took place in New York, argues that the durability of the structural relationships in healthcare was explained by the fact that dominant and challenging interest groups had a common interest in reaching a compromise, which acted to entrench the status quo. Alford (1975:254) argues that ‘government policy is not fundamentally important, except insofar as the policy is that of not interfering with the private sector’. Palmer and Short (2000:24) and Buse, Mayes and Walt (2005:6) suggest a view of policy as ‘embracing courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system’. This view is based on Hogwood and Gunn (1984:23) in which policy is distinguished from decision making, but is more closely aligned with ‘administration’ and involves behaviour as well as intention – policies have outcomes that may or may not have been foreseen. In this way the policy environment can exist outside
Government, with ‘policy processes neither overt nor clearly bounded’ (Walt et al 2008:310). In Australia, where the role of Government is both as funder and as planner of the health system, government policy includes what governments say they will do, what they do and what they do not do, a ‘set of actions and decisions or statements of intention’ (Palmer and Short 2000:23), in Hogwood and Gunn’s (1984) view ‘public’ policy provides the state a clear role.

Osborne (1997:174) suggests that most analyses of health policy appear to ‘adopt a reactive conception of the relation between health and policy. That is, on the one hand, policy is viewed as a reaction to objective problems of health need and provision, and on the other, the state of health is viewed as product of the relative effectiveness of policy’. This is a view also expressed by (Hajer 2003:182) who suggests the policy process is based on an understanding of policy as ‘intervention and a problem-orientation, culminates in notions of meaningful policy intervention to change a given course of events’. This view of policy underscores approaches to health policy analysis which seek to determine how to make policy – its structures, process and implementation – work to deliver a public good. Bacchi (1999:12) refers to problem solutions analysis which focuses on a belief that problems exist ‘out there’ to be analyzed. Anderson (1984) and Dye (1976) have been influential in conceptualizing the policy process as a sequence of events which Palmer and Short (2000) describe as problem identification and agenda setting, formation, adoption, implementation and evaluation: assuming a view of public policy as what governments do, why they do it, and what difference it makes. In practice the sequence of events is not linear ‘while policy refers to purposive courses of action, this does not exclude the possibility that purposes may be defined retrospectively’ (Hill and Hupe 2009:4). Sabatier (2007) criticizes this approach for suggesting clear demarcation lines between stages and offering no proposition on causality. Bacchi (1999) argues it oversimplifies the role of policy by ignoring the representation of the problem and the subsequent effects of that representation. Colebatch (2006:318) suggests in relation to the Australian setting ‘one of the most promising avenues to a new way of thinking about policy would be to focus on the way in which it is concerned with the generation of meaning. In this perspective, policy is better understood as a continuing process rather than a determinative choice, discursive and collectively constructed’, a view of policy applied to health policy by Fischer (2003) and Forester (1982). Policy viewed as
a process and a point of advocacy, aware of structural elements, requires an approach which is attentive to the issues of agency, governance and power.

### 2.3.2 The significance of agency in health policy settings

Health policy as a point of advocacy has focused on agency often utilizing Kingdon’s (1984) multiple streams theory to explain how particular health issues have emerged on policy agendas (see Reich 1995, Ogden, Walt, Lush 2003). Kingdon’s (1984) ideas of chance and serendipity as significant in agenda setting in which opportunities to act appear at the point of convergence of the three separate streams of problems, policies and politic. Recognizing different concerns between the different groups of participants in policy, Kingdon (1984) saw a role for policy entrepreneurs to act as brokers between different groups and their discourse to move issues between streams. Beyond serendipity the sociology of the professions has applied professional dominance as the analytical key to highlight the deliberate congruence of expertise and private and state patronage of scientific medicine that have secured corporatist medicine dominance in most industrialized countries. Willis (1989:18/9) found doctors in Australia are set apart from the other health professionals by the degree of specialized knowledge they have and the degree of power and control that can be exercised through the application of this knowledge. Expertise and knowledge structures matter in health policy settings because of the influence it affords to set agendas in support of institutional structures which favour a particular approach to healthcare over others (Abbott 1988, Freidson 1985, Germov 2005, Willis 1989).

Abbott (1988) argues that professional groups operate within a system in which each professional has command over a distinct set of tasks or problems which he calls ‘jurisdiction’. A profession asserts its right to a particular jurisdiction through the development of an abstract system of knowledge. Abbott (1988:56) suggests that professional jurisdictional control is maintained by an abstract and formal system of knowledge which accomplishes three tasks – legitimization, research and instruction. Professional practice gains the legitimacy of being scientific, logically rigorous and rational when bound in theoretical knowledge (Abbott, 1988:55). Formal educational credentials transform the acquisition of knowledge into an asset,
suggesting what is to be gained or lost in health reform. Freidson (1985:32) suggests that the concept of professions must be accepted as intrinsically ambiguous with no definition ever gaining general acceptance. Crompton (1990) argues that professions can best be understood as a mode of control. This view is useful because it centers interest on boundaries, control and status, and defensive tactics during periods of change which can help to explain behaviour (Ferlie, Ashburner, Fitzgerald and Pettigrew 1996:171). The state’s recognition of the medical professions’ jurisdictional claims – the occupational boundaries within which it monopolizes practice – is, Abbott (2005a) argues, more complicated than endorsement of a gatekeeper role. The state, like the professions, is a complex interactional structure filled with competing subgroups that fight for jurisdiction (Abbott, 2005a:247). In this context the interests of governments in health can be seen to be changeable. It is within this shifting terrain that states and the medical profession interact (Coburn, 2006: 435). Coburn (2006) and Abbott (2005a) suggest that as the government redefines its role in the healthcare sector, it may create struggles which could impact on the professions jurisdictional claims. The interest the state has in the profession, and the professions jurisdictional claims are the suggested area of analysis.

Alford (1975) argues agency is expressed through health policy reform and barriers to reform which should be viewed as the outcome of conflicts between three major health groups ‘professional monopolies’, ‘corporate rationalisers’ and ‘community interests’. The relevance of these categories to the Australian health sector has been assumed by Lewis and Considine (1999) and Duckett (1984:959), while Gillespie (1991:xi) cautions that ‘an adequate account of the relations of the state to the provision of healthcare must start from premises other than the stark opposition of ‘intervention’ and ‘autonomy’. This concern is echoed by Checkland, Harrison and Coleman (2009:621) whose analyses of the United Kingdom health system highlight that a richer understanding of the structural interests in healthcare is required, they found utility in categories such as ‘corporate monopolies’. Checkland, Harrison and Coleman (2009:623) argue that Alford (1975) was unspecific in explaining how new structural interests come about, and underplayed the role of Government. Marmor and Christianson (1982) apply a political economy perspective to explain why the effects of public medical care policy in America diverged from accepted notions of the public interest, introducing notions of imbalanced markets for health policies in which governments and professional monopolies play specific roles.
Marmor and Christianson (1982) suggest the role of government – the sources of its strength and weakness – as the focus for analysis in understandings of agency in health policy agenda setting.

2.3.3 Towards an understanding of governance in health policy

‘The literature on the causes of health care reform is dominated by institutionalist accounts, and political institutions are among the most prominent factors cited to explain why change takes place’ (Starke, 2010:487). Institutionalism, and in particular sociological and historical institutionalism (Hall and Taylor 1996), is drawn on in healthcare to explore how contingent political institution and policy legacies affect the policy process, primarily in policy studies focussing on the United States (see Hall and Taylor 1996, Lecours 2005, Scott, Ruef, Mendel, and Caronna, 2000). Institutionalism cuts across sociology, political science and economics drawing on a range of concepts, approaches and methodologies (Campbell 2004). New institutionalism, or neo institutionalism, also sometimes referred to as historical institutionalism, emphasizes the existence of structures and institutions (rules and roles) and struggles for legitimacy, viewing policy as a political process (Wilsford 2010:669). New institutionalism concerns itself with how practices become embedded, it is considered to be both a phenomenological process by which certain social relationships and actions come to be taken for granted and a point at which there exists shared understanding of ‘what has meaning and what actions are possible’ (Zucker, 1983:2 cited DiMaggio and Powell, 1991:9). From a policy perspective it is concerned with how the practices of political life shape organizational practices (March and Olsen 1984). From a policy analysis perspective the concern is how ‘policy action and inaction shape and constrain decisions within health authorities, hospitals and other organizations’ (Palmer and Short 2000:30). The persistence of practices in both their ‘taken-for-granted quality and their reproduction in structures that are to some extent self-sustaining’ is the focus of new institutionalism (DiMaggio and Powell, 1991:9). Scott, Ruef, Mendel, Caronna’s, (2000) interpretation of institutional theory describes three components: 1) institutional actors: 2) institutional logics: and 3) governance structures as the analytical tools which are useful in gaining an understanding of the institutional environment was applied in their study of the shaping of the American health system. Influenced by DiMaggio and Powell’s (1983) observation that organizations experience pressure to conform to their institutional environments
because of ‘coercive’ pressures from political institutions through the imposition of rules and practices, ‘normative’ pressures from professional (occupational) bodies which afford legitimacy, and ‘mimetic’ pressures from other comparable organizations to achieve greater outcomes, Scott, Ruef, Mendel, and Caronna, (2000:169) suggest an association between logics, actors and governance structure to a type of institutional order. This interpretation of institutionalism has been referred to as ‘organizational institutionalism’ by Campbell (2004). The coercive mechanism has been associated with regulative structures, the normative with normative systems and the mimetic with the cultural-cognitive order. Governance structures consist of normative and regulative elements. Institutionalisms focus becomes the institutional processes which shape technical/market arrangements and set up the framework for action: pointing to its popularity within healthcare policy analysis. Lounsbury (2008) describes the kind of rationality that institutionalists are embracing as a broad Weberian understanding of rationality as institutionally contingent. Neo institutionalisms attempts to explain rationally the political processes involved in the mechanics of behaviour change has caused it to focus on how new logics become embedded, at the exclusion of the role of power in influencing the dominance of particular logics. Neo institutionalism seeks to sanitize politics distracting it from the messiness of politics. Scott (2008) provides a possible explanation as a desire to be accepted, ‘A focus on the explanation of non-rational features of organizations threatened to condemn institutional theorists to play the role of subordinate hand-maiden to rational analysts (in their numerous guises), who would themselves attend to the adult concerns of constructing accounts of efficient organizations, leaving to institutionalists the scraps, accounting for the error-term in their equations’ (Scott, 2008: 436). Recently, Scott (2008) warned against the tendency to understate the extent to which the technical/market arrangements are themselves defined and constituted by institutional processes (Scott 2008: 436). Scott (2008) called for an acceptance of the duality of social systems as a product of deliberate human action and institutional forces, suggesting the need to focus on agency and power to avoid irrelevance (Scott, 2008: 436).

Institutionalist studies in healthcare have provided descriptions of episodes, deepening understandings of why things are the way they are. Béland (2010) criticises institutionalism for failing to explain the why of policy change focussing instead on how the politics affect policy. Applications of institutionalism in policy studies aimed at understanding healthcare governance
have found limited utility outside the United States, suggesting the difficulty of translating its approach across differing polity. Starke (2008, 2010), in studies of health reform in New Zealand, borrows from Dretske (1991) to suggest policy as an instrument to bring about reform deemed necessary due to triggering causes – all variables that explain the timing of reform – and structuring causes – which includes institutional filters such as political system variables and interest groups. This explanation takes policy beyond simple functionalist accounts and path dependency incremental descriptions, and introduces institutionalism to understand the political context, while drawing attention to institutionalism inability to explain content and timing of reform. Starke (2010:488) argues that ‘highly centralized polities such as Westminster systems are regarded as more prone to radical change than fragmented systems that offer many opportunities for opponents of reforms to veto legislative changes. Proposing a concept of policy as meaning making, Campbell (2002:21) called on institutionalists to take a cultural turn to recognise the role of ideas in driving change. Colebatch (2005:21) places this in the practical realm of the Australian health setting suggesting that policy work is concerned with ‘constituting a regime of practice which is congruent with the activities of existing players (whose concerns are legitimated by their standing as ‘stakeholders’). It is about negotiation as much as it is about selection. In this context, generating shared meaning is a critical part of the process’. Campbell (2004:6) suggests policy frames as a type of idea which affects institutional change and may be better able to explain the why of policy, but cautioned that institutionalism was ‘hobbled in these efforts because our work on ideas suffers from conceptual and methodological problems’ (Campbell 2004:6). A view of health policy in Australia as a process involved in governance and advocacy tied to polity, knowledge and intervention, supports a concept of policy frames as ideas bound up in discourse.

2.3.4 Concepts of power in health policy analysis

There are significant differences between the history of ideas and Foucault’s (1976, 1977, 1979) approach to the historical analysis of systems of thought and discourse. Where the history of ideas seeks to uncover cultural continuities and to isolate mechanisms of causality (Smart 2002:49), Foucault’s approach is to analyze and describe:
the domain of existence and functioning of a discursive practice… to discover that whole domain of institutions, economic processes and social relations on which a discursive formation can be articulate … to uncover … the particular level in which history can give place to definite types of discourse which have their own type of historicity, and which are related to a whole set of various historicities.
(Foucault 1977:164).

From a health policy perspective these differences suggest an approach through which the history of ideas which inform present health policy is seen not in the form of a single continuum, but as a set of diverse technologies of health, inclusive of administrative techniques and practices and other means ‘through which the impossible dream of a healthy population has been made an object of realisation’ (Osborne 1997:174). Foucault conducted a fieldwork of problematisations in technologies of health: tying these technologies to wider political rationalities of government to reveal the relations to power. Health informatics as an administrative technique would lend itself to such an approach, despite the rarity of applications of Foucault’s concepts to health analysis – possibly explained by its distance from natural scientific thinking, and overt critique of medicine and medical knowledge or tension with Foucault’s concept of power.

Walt et al (2008:310) describe the tension in the top-down, bottom-up decision making debate in the United Kingdom as related to notions of power describing: ‘the notion of ‘power’— fundamental to policy analysis—is a highly contested concept. Yet it is often used as if there were little difficulty in agreeing what power is, where it lies, and how it is exercised’. For Walt and Gilson (1994:355) ‘the process of policy-making (how issues get on to the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations’. This view of power suggests the relational aspect of power but points to power as something identifiable, measurable by the distance from it. It assumes a generally accepted understanding of the existence of, and form of, power structures. The Marxist critique of power which argued the state was not a disinterested institution promoting the public interest, but one exercising power in favour of dominant classes, has influenced understandings of power in policy analysis focusing on the influence of professional and state interests (Wildavsky 1987, Marmor and Christianson 1982:4-21), and in the discourse of
decision-making as top-down (Dye, 2001) – and has been influential on Foucault’s work (1976, 1977, 1979) investigating the techniques and practice of medicine. While the Marxist view has been criticized for overstating the role of the State in the exercise of power (Lipsky 1980), the idea that power is vested in relations and institutional actors has been accepted in investigations of agency and stakeholder relations.

The theory of interests (Lukes 1974) has been applied to health policy by Allsop (1984) in the United Kingdom and Hancock (1997) in the Australian setting. The theory of interests suggests a view of power as: ‘Power refers to every possibility within a social relationship of imposing one’s own will, even against opposition’ (Palmer and Short 2000:51), where one’s own will is known and owned. Assuming a three dimensional view beyond the subjective view of interests as policy preferences, to include an objective view of interests emphasizing attitudes and preferences shaped by conditions which may be unconsciously understood – a use of power which circumvents ‘overt conflict of subjective interests from arising in the first place’ – and a view of interests as establishing the rules of the game (Palmer and Short 2000:51). ‘A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants’ (Lukes 2005:27 cited Howarth 2010:321). Lukes (1974:24-25) proposes that power relationships constitute ‘a contradiction between the interests of those exercising power and the real interests of those they exclude’, real interests are those things actors ‘would want and prefer, were they able to make the choice’ (Lukes 1974:34). The importance of hegemony is recognized in the existence of a set of beliefs that operate to legitimate existing power relations. Lukes (1974:22) proposes exercises of power that (a) do not entail observable conflicts, but rather latent conflicts: (b) are a ‘function of collective forces and social arrangements’. In Lukes (1974) concept of power, it involves inaction, can be unconscious, and can be wielded by identifiable groups or institutions. From this perspective policy cannot be viewed as simply a set of officially endorsed objectives. Hancock (1997) argues that ‘integral to discussions about power in health policy are debates about the hegemony of medical power/knowledge’. Hancock (1997) found ‘new paradigms of power though budget control and managerialism’, noting ‘the neoliberal state reform agenda is not so easily detected or controlled by medical interests… the broad and pervasive context of market rationalities sets rules like the air we breathe’. Colebatch (2005:21) suggests recognising
Policy as ‘a structured commitment of important resources’ (Schaffer 1975), ‘including organizations, discourses and technologies of rule. It has to be understood as part of the institutionalisation of social practice, the way that public authority is mobilised to shape practice in multiple and diverse fields of action, such as workplace relations or child rearing or water use’.

Bradshaw (1976:121) stresses the difficulties in Lukes’ ‘real interests’ approach as real interest are imputed onto social action yet the reasons for accepting or adopting these is not clear (Howarth 2010) and claims to be both ‘empirically applicable’ and ‘essentially contested’ are seemingly incompatible. While in his later works (Lukes 2005, cited Dowding 2006) distanced his work from Foucault by suggesting that there are those that are dominated and acquiesce, and those who dominate, Foucault sees all social relations as constituted of power: ‘power is exercised rather than possessed: it is not the privilege of a dominant class, which exercises it actively upon a passive, dominated class. It is rather exercised through and by the dominated’ (Sheridan 1980:139). There are, however, many similarities between Lukes and Foucault’s concepts of power, not least the hidden or unremarkable, everydayness of power. Yet the differences are significant, Foucault (1979, 1986) sees resistance as constituent of power while for Lukes (1974) there must be an intention for power, the intention is to dominate (Dowding 2006) requiring acquiescence. For Foucault, power cannot be used in an instrumental fashion, it is not a thing, it cannot be wielded because it does not exist as ‘a capacity vested in actors or institutions’, ‘it cannot be reduced to structural properties or causal agents’ (Howarth 2010:323) – it is a relational concept, which is immanent, a strategy ‘without subjects’ (Foucault 1982b:220), the ‘conduct of conduct’ exercised in the act of self governance. Interpretation of Lukes’ (1974) concept of power has viewed his notion of the third dimension of power to be more simply construed as manipulation (Elster 1983). The starkest difference between the two is arguably Foucault’s (1980:119) view of the positive effects of power ‘what makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than a negative instance whose function is repression’.
Foucault introduces the concept of power as guidance, as governmentality, which does not exclude consensual forms, nor does it suggest that power is unnecessary (Foucault 1982b:219-222). For Foucault the problem is to see how people govern by the production of truth. Government refers to a technology of power which can be considered as systematized, regulated and reflected modes of power. The art of government is not limited to the field of politics as separate from the economy: instead the constitution of a conceptually and practically distinguished space, governed by linguistic and other rules, and a proper rationality, is itself an element of economic government (Foucault 1979:93-97). While politics and government are indivisible, Foucault does not limit the field of power relations to the government of the state: Foucault sees the state as nothing more that the mobile effect of a regime of multiple governmentality. It is necessary to address from an exterior point of view the question of the state, it is necessary to analyze the problem of the state by referring to the practices of government (Foucault 1984:21, cited Lemke 2002). He emphasizes that ‘it is the tactics of government which make possible the continual definition and redefinition of what is within the competence of the state and what is not, the public versus the private, and so on: thus the state can only be understood in its survival and its limits on the basis of the general tactics of governmentality (Foucault 1991b:103). The created contexts which redefine the boundaries of government responsibility are suggested as a starting point for policy analysis interested in power.

This study is interested in understanding the impact of policy on adoption behaviour and requires an explanation of the will to act. For Foucault the focus becomes how sets of beliefs are shaped to encourage one to perceive action as the exercise of one’s own will – to self govern. Osborne (1997:174) laments that the Foucauldian approach which views health policy as a social construct has often been applied to suggest medicine as colonising the social field in a negative way – referring to David Armstrong’s (1983) ‘Political anatomy of the body’ as radical constructualism – while offering an possible explanation for why Foucault has been relatively ignored in health policy analysis. Foucault appears to have substantial utility for health policy with his focus on knowledge/power structures, discipline and governance which could provide a focus for understanding the complexity of a policy as a process involved in governance and advocacy tied to polity, knowledge and intervention. Osborne (1997) argues that instead of
saying issues of health policy are simply constructs, it can be said that such issues are products of particular problematisations (Foucault 1986). ‘Problematisations are not modes of constructing problems but active ways of positing and experiencing them’ (Osborne 1997:175). Policy, conceived as a strategy, ‘cannot get to work without first problematising its territory – this means policy is fundamentally a creative rather than a reactive endeavour’ (Osborne 1997:175). Osborne (1997) describes the function of problematisations as reducing complexity, ‘to provide a field of delimitation regulating what can and cannot be said’, limiting debate and encouraging action. Notions of problematisation are tied to the ‘art of government’ (Foucault 1979). The constitution of authority over particular problem areas ‘whether it resides in the professions, the state or law – is never just given or constructed in the abstract but always problematised, negotiated and constituted’ (Osborne 1997:175). Foucault suggests a way of tying discourse theory – discursive practices in which subjects are legitimised in claims to truth claims about objects that are constituted within particular discursive formations supported by institutional arrangements including expert knowledge systems - to political practice, providing a way of conceptualising forms of rule and their maintenance allowing for an illustration of how policies are transformed into practice.

Foucault (1986:234) provides a concept of power stated as:

> Power must be analyzed as something which circulates, or rather as something which only functions in the form of a chain. It is never localized here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads: they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target: they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application.

Foucault identified ‘the rise of disciplinary power, focusing upon maximizing the utility and docility of individuals, and bio-power, focusing upon maximizing the health and welfare of the population … Discipline individualizes and normalizes, and bio-power collectivizes and socializes: ethico-politics concerns itself with the self-techniques necessary for responsible self-government and the relationship between one's obligation to oneself and one's obligations to
others’ (Rose 1999:4). Rose (1999:15) defines this view of the social and political analysis as governance:

a kind of catch-all to refer to any strategy, tactic, process, procedure or program for controlling, regulating, shaping, mastering or exercising authority over others in a nation, organization or locality.

Rose (1999:22) suggests ‘it thus seems to me to be useful to regard the notions of government and governmentality as marking out, in the most general way, the field upon which one might locate all investigations of the modern operations of power/ knowledge’. Governmentality, which Foucault conceptualizes as the construction of ‘mentalities of governing, the way in which practice is problematised, expertise is brought to bear, and programs of actions are recognized as appropriate response’ (Colebatch 2006:313). The way in which issues appear on the policy agenda and the acceptance of the proposed solutions as the right thing to do suggests power/knowledge as the focus for health policy analysis.

The problem of how to conceptualize power and relate power to notions like discourse and how to integrate these ideas of power into a conceptual framework for policy analysis is revealed in the analysis of health policy studies literature. A conceptual framework which allows for the exercise of power to be viewed as constituent in health practices is suggested by the literature. This study aims to illustrate that the critical interpretive perspective applied to an understanding of health policy as a process constituent of power relations, a process involved in governance and advocacy tied to polity, knowledge and intervention, is not just an interesting academic exercise, it can contribute to an understanding of the mobilization of authority, the impact this has on interpretation of policy intentions and on behaviors to act in relation to policy. This ascribes for policy analysis a role beyond ’advising the government’.

To assume this role, the target of analysis isn’t institutions, theories or ideology, but practices (Foucault 1981:75), where practices are the places where the rules are imposed on what can be said and done, where ‘the planned and taken-for granted interconnect’ (Foucault 1981:75). The focus of the eHealth policy analysis is on the intention of the practices being introduced. Attention now turns to the concepts of power and politics which can inform an understanding of the practice of systemizing information.
2.4 The Concept to Power in IS Research

2.4.1 The challenge of power and politics in understandings of information systems

The Information Systems research field has a recent history (Hirschheim and Klein 2003:237). The focus of Information Systems research has not been on the act of systemizing information but on the development and deployment of computerized information systems, primarily into organizations (Hirschheim and Klein 2003:237). However, it has as a central concern information and systemization of information. Given the recent interest in information systems research, explorations of power and politics in information systems, while immature, have received consistent attention. Keen (1981) recognizing the ‘link between information and power’ called for a greater appreciation of the impact of information systems to ‘alter relationships, patterns of communication and perceived influence, authority and control’, and suggested ‘a strategy for implementation’ which dealt with the ‘politics of data and the likelihood, even legitimacy, of counterimplementation’ (Keen 1981:24). Keen (1981) describes an association with politics as an unwelcome interference in information system deployments as hampering progress on the political perspective.

Unfortunately, ‘politics’ have been equated with evil, corruption and, worst of all, blasphemy in the presence of the Rational Ideal, but politics are the process of getting commitment, or building support, or creating momentum for change: they are inevitable ... It is absurd to ignore it ... A political perspective on information systems is needed in research... It can immensely add to our understanding both of the implications of information technology and the dynamics of effective implementation. (Keen 1981:31)

The relationship between the rational ideal and political power has a strong history (Foucault 1982a780). Keen (1981) encourages an understanding of political power as the capacity to influence the interpretation of an organizations rules or action to encourage behavior of others in accordance with wishes which are not their own. In Keen’s (1981) view power could be obtained through an understanding of change management, combined with authority to make the rules: ‘The strategy for managing social change is based on acceptance of the political nature of
information systems development and the need for suitable authority’ (Keen 1981:31). Keen (1981) did grant certain forms of resistance legitimacy, acknowledging two kinds of resistance ‘honest resistance to a project one feels is misguided and selfish sabotage of a necessary innovation’ (Keen 1981:28). This view of power and resistance influenced Keen’s (1981) findings that data are not merely an intellectual commodity but a political resource which could be appropriated. These notions of information and power resonate in understandings of information: ‘Information is a resource that symbolizes status, enhances authority and shapes relationships’ (Wildavsky 1979), ‘Information is an element of power’ (Greenberger, Crenson, Crissey 1976). Despite Keen’s (1981) leanings towards a structuralist approach to viewing power as a resource to be obtained and managed, his view of power goes beyond the view drawn up by Dahl’s (1957:202) in which power is defined as A exercises power over B when A makes B do something B would not otherwise do. Keen’s understanding of power suggests a greater alignment with Bachrach and Baratz (1962) who describe power as pervasive, and its affects obscure – including in their understandings non action as a form of power.

The epistemological challenge which Keen (1981) identified for IS researchers’ lay in the obscurity of studies of politics that ‘involve hidden agenda (counter implementers do not boast about their triumphs) and in most instances a skilled observer has to ferret out and interpret what has happened … the work on implementation is almost entirely narrative and descriptive … will often be case studies which does not mean they are not legitimate research’ (Keen 1981:32). Keen’s (1981) conviction that it was fundamental to understand power and politics to implement IS encouraged the call for expansion beyond traditional approaches to IS research, while not questioning the act of systemizing information. The call for broader social economic and political interpretations of the impact of information systems on the behaviour of individuals was a concern for Kling (1980) who was active at that time (Robbin 2007). Kling was concerned with: What kinds of impacts do computer based information systems have upon public agencies and the polity? What are the social consequences of using computer based technologies? (Kling, 1987:307–308). Kling (1980) understood how political processes were intrinsic to decisions about computerization and its consequences, and he employed political theory to find explanations for his observations. Robbin (2007) summarises the contribution of Kling as
introducing a critical approach to social informatics and an interpretive epistemology to information systems research:

These dominant theoretical approaches to modelling technology adoption suggest that technology shapes organizational practices in an ahistorical, deterministic and unidirectional causal direction. However, the theoretical claims made by these approaches do not adequately correspond to what I have observed in my investigations of public and private organizations. I have thus extended my theorizing to incorporate multiple theoretical perspectives and, in particular, various forms of interpretive epistemology and associated methodologies to study organizational practices (Robbin, speaking as Kling 2007:238).

Kling (1987) conceptualised technology adoption as a contingent process mediated by history, context, political and social processes. Unlike the rational perspective, which assumes objectively identifiable, unified goals and roles and the pluralist perspective which posits distinct, objective goals and resources, the interpretive perspective deals primarily with perceptions and the processes that shape them, allowing room for a more complex explanation of power as relational and dynamic (Jasperson, Carte, Saunders, Butler, Croes, Zheng, 2002:407). From the interpretive perspective, power is defined in terms of actors' ability to control and to shape the dominant interpretation of events (Silva 2007). Sense making and recognizing the right way of doing things is considered a political dialog through which influence is exercised (Jasperson et al, 2002). From the interpretative perspective, reality is both individually and socially constructed becoming reified as objective knowledge (Brooke 2002:50). Kling and Iacono 1984 and Robey and Boudreau 1999, placed emphasis on language and symbolic processes focusing on the combination of discourse, persuasion (accountability), and communication to shape the reality of information technology, rather than viewing power as derived from control of resources or formal authority - highlighting their migration from a simple structuralist approach to an interpretative approach. Kling’s (1992, 1999) focus on organizations and institutions as symbolic system aligned him with the new institutionalism (Scott, Ruef, Mendel, Caronna, 2000, DiMaggio and Powell 1991) and its focus on legitimacy as a complex process essential to organisational survival (DiMaggio and Powell 1991).

Institutional environments are seen to influence the organization through ‘archetypes they develop for actors, the logics they legitimate, and the governance systems and rules of social
action they support’ (Scott, Ruef, Mendel, Caronna, 2000:166). Studies utilizing institutionalisms framework demonstrated information system to be a politically and socially contentious innovation which encompassed a range of interpretations across different institutional groups, including that of political tool (Covaleski, Dirsmith and Michelman, 1993:65, Currie and Guah 2007). Yet institutionalisms concern with the mechanics of changing behavior is limited by its detachment from the intentionality of influencing the dominance of particular logics, focusing instead on how new logics become embedded. Despite Kling’s concern with key national discourses about technology which he regarded as shaped [framed] by commercial interests and government agencies in a way that let them to advance their interests through unfettered technological experimentation (Kling 1992:351), Currie and Guah (2007) acknowledge ‘institutionalists concede that agency is underplayed in much of the literature’ (Currie and Guah 2007:246).

The contribution of an interpretative perspective to an understanding of information systems as a political tool has been drawn out in the IS literature: however, agency has been underplayed. The politics of power, its impact on behaviour, and identifying beneficiaries, cannot be underplayed if we are to inform an understanding of the role of information systems in the political environment. Silva (2007) recommends an approach which unravels rather than judges political maneuvers made by actors in and around IS, supporting Keen’s (1981) call for a more accepting attitude to the necessity of power.

2.4.2 Concepts of power in IS research

Diverse concepts and understandings of power exist in IS research. The relationship between resistance to the adoption of new systems and power has been explored by Kling (1980), Markus (1983) and Buchanan and Badham (1999) who describe resistance to adoption as contributory to struggles for the exercise of power. Markus (1983) highlights the political variant as the most appropriate analytical framework when organizational participants disagree about the nature of the problem that the system is proposed to solve, and when the power bases are highly valued (Markus, 1983:443). The interaction between the system being implemented and the context of use was explored by Markus (1983) who found that attitudes towards adoption were positively
influenced when it is believed the system will support a position of power. If it is likely to cause a loss of power, it will be resisted. This view of power suggests power as an identifiable thing, which is either gained or lost, involving winners and losers, and having a ‘right’ balance. A number of studies investigating the strategies and tactics used by stakeholders to influence information system development building on the work of Kling (1980) and Markus (1983) - (Franz and Robey 1984, Lyytinen and Hirschheim 1988, Markus and Robey 1983, Robey 1984, Robey and Markus 1984, Newman and Robey 1992). While an interpretative perspective was adopted, a conception of power as externalized behaviour or as bases or resources was invariably used suggesting a reliance on Dahl’s (1957) explanation of power. Markus and Bjorn-Anderson (1987) extended the view of power to stress the different faces or dimensions of power through power relations examining the power of IS professionals’ over users. However, much of the research building on Markus and Kling sought a way to categorize or measure the influence of power rather than unravel it, employing a positivist approach in understandings of power as a resource. This, in part, can be explained by the understanding given to the ‘external’ relevance of IS research which is defined by its ability to serve the interests of ‘the most commonly espoused external stakeholder groups, i.e., industry management’ (Hirschheim and Klein 2003:250, Klein and Hirschheim 2001). Notwithstanding, Markus highlights information systems role in enabling a power shift in organizations and emphasizes the role explanations of resistance play in guiding behavior and influencing the actions taken in developing and implementing information systems.

In an era of network governance and in purchase-provider arrangements, power relationships are perceived as mutually interdependent. Orlikowski (1992) presented a concept of technology useful in understanding power as a mutual interaction between human agents and technology, as both structural and socially constructed, yet embodying an instance when the rules and resources which constitute the structure of the organization apply (Orlikowski, 1992:405). Orlikowski (1992) combines the idea of legitimate power as derived from formal structures of authority embedded in technology (Mintzberg 1983, Weber 1999) and the possibility for interpretation of the rules contained within technology. The idea that technologies are products of their time and organizational context, reflecting the interests and conditions at a given place in history (Orlikowski 1992:421), limits an understanding of information systems as an idea which is
distinct from the artifact. The limitation of this view on explanations of power is that it denies agency to information systems. A role for information systems which has both context and history and is independent of the type of technology is needed to understand the impact of and on the political environment. A view of the role of technology which does not decouple the artifact from human action, while recognizing what Orlikowski (1992) calls the duality of technology in facilitating decentralization and flexible operations on the one hand, and increasing dependence and centralized knowledge and power on the other hand (Orlikowski, 1992:410) would better respond to the obscure nature of power.

2.4.3 A critical view on power in IS research

Explanations of power in information systems which seek an alternative to a structuralist or positivist/determinist perspective have contextualized the introduction of information systems in the broader political environment. Doolin and Lowe (1999) concentrated on how information systems were used to influence behavior and practice in the context of larger political changes in New Zealand. Doolin and Lowe (1999) investigated resistance to an information system from the perspective of the power relations of key stakeholders using a critical interpretivist approach, questioning the commonly held assumption that IS deployment reflects efficiency-seeking. Doolin and Lowe (1999) describe resistance in terms of its everydayness, as subtle and outcomes as unclear. Corbitt and Thanasankit (2002) investigated various national policy directions in support of eCommerce: the study did not concern itself with the adoption of e-commerce, but with the adoption of the e-commerce policy direction: providing insight into how intent is interpreted: ‘Power may be exercised in a number of ways including through misinformation, decision-making, agenda setting and in the shaping of felt needs’ (pg 41). Rose and Miller (1992) also acknowledged the normalness of power, advocating investigations of the mundane programmes, calculations, apparatuses, or ‘governmental technologies’ which become significant for their enactment of powers ambition. Power and resistance as both obvious and hidden in the everyday is highlighted through a critical lens.

Critical research has a reputation for pulling reality and concepts apart providing a way of unraveling power at work. Critical theories epistemology is ‘a mixture of psychoanalysis and Marxism’, and its aims are to expose the techniques of science and technology embraced by the
rational agenda which ‘constrain humans in programs of control and efficiency’ (Silva 2007:171). In the study of information systems, critical theory posits that technological artifacts are the result of political struggles and ascribes a role for information systems as the sites for diffusion of interests (Callon 1987, Ihde 1990, Latour 1993). The epistemological and methodological challenges of a critical approach have been suggested by Brooke (2002:50) to explain Alvesson and Willmott’s (1996:149) criticism that ‘critical theory in IS is comparatively recent and is still at an early stage. It has yet to progress much beyond a critique of existing approaches to systems development’. Critical Systems Thinking throughout the 1980’s and 1990’s drew almost exclusively on Habermas (Valero-Silva 2001, Brooke 2002, Richardson and Robinson 2007). A critical perspective to the extent to which organizations are ‘the primary institutional carrier for the diffusion of technical or instrumental rationality’ (Brookes 2002:50) was found utility for Habermas (1972, 1984). Habermas (1984) call for an ‘enlightened suspicion of the enlightenment’ describes his stance as skeptical of positivism while not advocating its abandonment. Lyytinen and Klein (1985) promoted Habermas’ (1984) typology of action, which included purposive-rational action and communicative action, within IS research. The appeal of Habermas to IS researchers’ was suggested by Brookes (2002:52) as methodological simplicity – ‘he provides a more easily ‘modeled’ set of frameworks for application’. Habermas (1984) notion of rationality and pursuit of an understanding of the rationale underlying how individuals express themselves- conceptualizing and analyzing rationality as a global process (Smart 2002:138) - is credited with its appeal in IS. The critical leanings of Habermas (1984) are its focus on emancipation, expressed in his call to identify obstructions to discourse which undermine mutual understanding. This view gives rise to a normative guide for action allowing for the creation of models for framing analysis – suggesting the possibility of consensus. The construction of a legitimization process for discursive evidence, the normalization of language in which evidence is understood to be neutral and ‘true’, and the norms generated which enables mutual understandings, are not questioned in Habermas analysis. While Habermas (1984) recognizes fragmentation to the interpretation of and access to truth can occur, the purpose of this fragmentation is not explored. The limitations of Habermas analysis may explain why criticisms of inadequate conceptualization of power within critical IS research persist (Brooke 2002, Silva 2007, Jaspersen et al 2002).
It is not the intention of this literature review to enter into the debate of Habermas versus Foucault, but to gain a richer understanding of the concept of power in Information Systems. While Habermas work has dominated critical IS research, Foucault has made inroads – see for example Brigham and Corbett (1997), Knights, Murray and Willmott (1997), Doolin (1998), Doolin and Lowe (1999), Doolin and McLeod (2005), Nguyen, Torlina, Peszynski and Corbitt (2005), Peszynski and Corbitt (2006).

For Foucault, the question of power is:

How, not in the sense of How does it manifest itself? but By what means is it exercised? and What happens when individuals exert (as they say) power over others? 
(Foucault 1982a:788)

Power is conceived as a strategy rather than a possession (Smart 2002:77). What characterizes power ‘is that it brings into play relations between individuals (or between groups)’ (Foucault, 1982a:786). Foucault, like Habermas, recognizes communicating ‘is always a certain way of acting upon another person or persons’ (Foucault 1982a:786), however, beyond the systems of ‘language’, ‘signs’ and ‘other symbolic medium’, ‘the production and circulation of elements of meaning can have as their objective or as their consequence certain results in the realm of power’ (Foucault 1982a:786) and are of prime concern. In conceptualizing power relations as separate from the systems of communication, Foucault ascribes a purpose to the fragmentation of interpretations of truth.

Conceptionalizing power as relational, Foucault (1982a:788) suggests:

The exercise of power is not simply a relationship between partners, individual or collective: it is a way in which certain actions modify others. Which is to say, of course, that something called Power, with or without a capital letter, which is assumed to exist universally in a concentrated or diffused form, does not exist. Power exists only when it is put into action

Power relations are presented as situated action, as self-reproducing and immanent, and changing over time. Power is constituted in relationships to which we are all implicated:
between a relationship of power and a strategy of struggle there is a reciprocal appeal, a perpetual linking and a perpetual reversal. At every moment the relationship of power may become a confrontation between two adversaries (Foucault 1982b:208)

The mutual interdependence of power and resistance is emphasized: power requires resistance for its enactment. In this way Foucault suggests the act of opposing regimes of power implicates us in power. Foucault (1982a:780) proposed that the focus of studies of power should be sites of resistance: ‘Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies’. To unravel the modern exercise of power the neglected struggles which are not against an ‘institution of power, or group, or elite, or class’ but rather ‘a technique, a form of power’ should form the focus (Foucault 1982a:780). Foucault presents the concept of governmentality: ‘Governmentality is the ‘ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has as its target population’ (Foucault 1979:20). Foucault defines government as the conduct of conduct and as a term which ranges from governing the self to governing others. Government refers to a technology of power which can be considered as systematized, regulated and reflected modes of power. Technology in this sense refers to forms of managing and activating a population, ‘in Foucault's terms we would see policy ensembles that include, for example, evidence, accountability, performance metrics as 'regimes of truth' through which people govern themselves and others’ (Ball, 1993:14). Lingard (1991) describes an amalgam of discourses that constitute a technology of power in forming his concept of corporate federalism. Extending beyond ‘the spontaneous exercise of power over others’, government power instead follows a specific form of reasoning (a rationality) – through the creation of self-evident truths - which defines the actions that are possible (Lemke 2002:56). Government is the regulation of conduct by the more or less rational application of the appropriate technical means (Hindess 1996:106). Foucault directs researchers towards the overlooked resistances to specific forms of reasoning to understand the impact of power. The form of power being resisted is that ‘which imposes a law of truth on him (the individual) which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects’ (Foucault 1982a:780).
The concept of power Foucault presents is of a ‘complex strategical situation’, a multitude of force relations, as intentional, yet ‘nonsubjective’ (Smart 2002:77). Individuals do not possess power, are not agents of power and are also not crushed or alienated by it:

One of the prime effects of power is that certain bodies, certain gestures, certain discourses, certain desires come to be identified as individuals. (Foucault 1991b:98)

Foucault (1991:98) suggests a concept of power as influencing an individual’s interpretation of actions as the right thing to do, as taken-for-granted, the discourse of right which legitimates authority. Foucault (1991:89) challenged traditional idea about power to suggest that power is both good and bad, that power relations are essential for societies to operate. A society without forms of power relations and struggles to influence interpretation and action is inconceivable to Foucault (Smart 2002:133).

Foucault sought a more complex conceptualization of power than the traditional Marxist economic analysis of relations of production and class domination, criticizing the notion of power based on repression as contributory to the reification of authority itself (Foucault 1991b:89). Responding to how power is exercised, Foucault’s (1976: 1977: 1979: 1980: 1982, 1991) concept of power relations consisted of two reference points, bio-power and disciplinary power. Bio-power operates through establishing and defining what is normal or abnormal, and consequently what is socially deviant or acceptable in thought and behaviour supported as irrefutably right by knowledge structures (Buchanan and Badham, 1999). Statistics, ‘the science of the state’, are viewed by Foucault as a technology of the Government (Foucault 1979). The analytical challenge becomes to question what is ‘right’, why is the status quo, what are the taken-for-granted ideas in order to unravel power. The second reference point identified by Foucault (1976: 1977: 1979: 1980: 1982) was disciplinary power. Disciplinary power operates through the construction of social and organizational routine, targeting individuals and groups – described as a ‘fundamental instrument in the constitution of industrial capitalism and of the type of society that is its accompaniment’ (Foucault 1991:105, cited Smart 2002). The exercise of disciplinary power is intimately associated with ‘apparatuses of knowledge’.
…the production of effective instruments for the formation and accumulation of knowledge – methods of observation, techniques of registration, procedures for investigation and research, apparatuses of control (Foucault 1991b:102)

Power is diffused through a set of techniques whose effects are achieved via disciplinary practices, the tools of surveillance, comparison, judgment and assessment to control and regiment individuals (Buchanan and Badham, 1999). Foucault’s (1976: 1977: 1979: 1980: 1982, 1991) concept of power sees disciplinary and bio-power act together to bring about self monitoring of behaviour: influencing and controlling action to ensure compliance.

A Foucauldian perspective provides a means of understanding the nature of power as the ability to direct the processes of knowledge, those processes which create, shape, disseminate and validate understanding. Foucault’s interest in genealogy of knowledge and insight into power relations presents the basic claim that political power and scientific knowledge are not external to one another, in this way truth is characterized by power/knowledge relations present in discourse (Smart 2002). Arguing that power is inseparable from knowledge and that, since knowledge requires records and a system of communication, Foucault suggests it in itself is a form of power (Foucault 1977:66). Foucault presents the possibility for a conceptualization of information systems as discourse, as the medium through which power relations create speaking subjects. Additionally, Foucault posits that epistemological development within IS functions politically (while not referring to IS directly, Willcocks 2006:276) and are intimately implicated in the practical management of social and political problems. A Foucauldian perspective with its notion of power which moves beyond an ‘information is power’ distortion to the idea of power as a relationship, suggests the possibility of a role for information systems as a political tool which can facilitate a transfer of power.

Foucault presents a conceptualization of power as complex, multilayered, relational, situated in action, as both good and bad, and as fluid. However, Foucault does not provide a normative guide for action (Brooke 2002:55). Foucault describes his practices as ‘analytical work rather than theory and his analysis of power relations as ‘not a theory, but rather a way of theorizing practice’ (Willcocks, 2004:276). Locating power in situated action, Foucault casts each situation in a different set of historical circumstances and transformations – from his writings on madness.
and reason, the conditions of possibility for developments in medical knowledge, the emergence of human sciences, and later power-knowledge (Smart 2002:14). Foucault does not attempt a definition of power or present a theory of power. Foucault (1982a:778) asks:

Do we need a theory of power? Since a theory assumes a prior objectification, it cannot be asserted as a basis for analytical work. But this analytical work cannot proceed without an ongoing conceptualization. And this conceptualization implies critical thought - a constant checking. The first thing to check is what I shall call the conceptual needs. I mean that the conceptualization should not be founded on a theory of the object-the conceptualized object is not the single criterion of a good conceptualization. We have to know the historical conditions which motivate our conceptualization. We need a historical awareness of our present circumstance.

Foucault (1982, 1991) argues that to produce an explanatory theory of power normalizes power, reinforcing its ability to be exercised. A theory of power does not facilitate critical inquiry (Brooke 2002:55), but the absence of one does introduce epistemological challenges for IS researchers’. Foucault does not present ‘a concrete theory that analytically conceptualizes power in terms of its components’ and directs researchers to ‘concrete pieces of the data they need to claim validity in their interpretations’ (Klein and Myers 1999, cited Silva 2007:174). What Foucault offers to IS research is a concept of power that a) is present, b) is obvious and hidden, c) operates through taken-for-granted mundane routines and techniques, d) ascribes resistance a central role for in the exercise of power, and e) crucially provides a more direct analysis of power relations. Foucault directs investigation towards the neglected resistances in the history of the systemization of information offering the opportunity to remove the obscurity of the political role assumed by information systems in disciplining and regimenting individuals (Foucault 1977), and opening up the practices of challenge and resistance to analysis (Buchanan and Badham, 1999).

Foucault’s (1976, 1977, 1979, 1980, 1982) concept of power has found application in IS research, often being used to describe roles for IS in surveillance. Willcocks (2006:275) identifies Lyon (1988) and Dandeker (1990) as ‘being representative of a number of writers in the late 1980s discussing the electronic panopticon, the carceral computer, and the electronic eye’. This work was continued into the 1990’s to explain the role of information systems in facilitating a calculative form of control through computer-based surveillance and monitoring by
Orlikowski (1991), Bloomfield and Coombs (1992) and Ball and Wilson (2000). Willcocks (2006:281) cites Davies and Mitchell (1994) as extending the application of Foucault arguing that Foucault’s genealogical method, focus on history, and his concept of power/knowledge are particularly relevant in the study of emergent organizational forms. Willcocks (2006:281) credits Davies and Mitchell (1994) with demonstrating how Foucault’s work ‘on the regulatory nature of discourse within contextual histories can be used productively in IS studies, in this case that of IT manipulation in an Australian state government department’. The research demonstrated the application of Foucauldian principles to the discursive context of IT use in an organization illuminating the affect of power and politics in constraining and directing. The research suggests roles for IS in augmenting, reinforcing the status quo, or transforming. Foucault’s positioning of resistance was underutilized by Davies and Mitchell (1994), to be explored more fully by Doolin (1998). Foucault (1982a:780) encouraged investigation of opportunities for resistance which are located in relation to the techniques or practices of organization. Acknowledging that resistance is always possible, Doolin (1998) introduced the idea that IS are not always constraining but also opens up new discursive spaces for action. ‘Disciplinary technologies such as comparative surveillance information systems are not exclusively constraining. Indeed, such systems are ‘double-edged’, in that they also empower by providing a legitimate space for action’ (Doolin 2004:346). Applying Foucault to the practice of introducing an information system in a healthcare setting, Doolin (1998) demonstrated that clinicians often appropriated and manipulated the information and rhetoric of the system, diverting disciplinary practices to their own ends, principally in arguing for more resources. The information system became ‘the currency of debate, the principal media through which claims to legitimacy and control were processed’ (Willcocks 2006:282). Doolin (2004) drawing on Bloomfield (1995), Latour (1993), Knights and Murray (1994), and Miller (1994) positions information systems as part of processes in which both technology and organization become redefined: ‘information systems can influence which organizational actions and their consequences become relatively more visible. They become ‘mechanisms around which interests are negotiated, counter claims articulated and political processes explicated’ (Doolin 2004:343). Doolin suggests social relations are mediated through technology, and by the knowledges and practices which structure the field of possible actions.
Analysis of the literature supports calls by Richardson and Robinson 2007, Alvesson and Deetz 2000, Doolin 2002, Doolin and McLeod 2005 for a critical interpretativist approach in Information Systems research. Walsham’s (1993) and Boje’s (2001) call for caution with this approach, in which they suggest that attention be paid to the very different emphases of the approaches - interpretative focus on description and understanding, while critical theory has as its focus emancipation and the importance of values – will be responded to by adhering to the critical interpretivist methodological position described by Putnam (1983), Doolin (1998), and Doolin and McLeod (2005). Emancipation and the importance of values differentiate the Foucauldian perspective from other critical theorist (Myers and Klein 2011). Foucault’s rejection of the sovereignty-law-repression explanation of power, his rejection of the idea of normative values (Myers and Klein 2011:26), and his challenge to ‘an idea central to critical theory: that relations of power are not something bad in themselves and something from which one must be emancipated’ (Brooke 2002:53), have led to suggestion that Foucault offered little in respect of a value position (Brooke 2002:53, Myers and Klein 2011:26). Yet, as Myers and Klein (2011:26) note, Foucault (1991) was ‘critical of the so called new treatments of mental illness, which he argues amounted to no less than repeated brutality’. It could not be argued that Foucault’s approach was other than a critical perspective despite his not having provided an explicit value position. Foucault’s concept of power as present, situated and multilayered suggests it applicability to investigations of power in Information Systems deployment. A critical approach adopting a Foucauldian conception of power must respond to the challenges of a research approach which is not easily modeled, and must take into account the criticisms which are said to limit the approach. The discussion will now turn to the criticisms of Foucault’s concept of power.

2.4.4 Criticism of Foucault’s concept of power

Foucault’s work on power has received criticisms predominantly from those located within a Marxist problematic (Smart 1983, Lecourt 1975, Poulantzas 1978). Smart (2002:124) summarizes the criticisms as, the lack of a ‘class point of view’, its failure to address the importance of the state in modern societies, a ‘blind distinction between discursive practices and non discursive practices’, which can only be adequately formulated in terms of the concepts of
historical materialism. For Poulantzas (1978:148) Foucault’s conception of power relations lacks a precise basis or foundation because it does not explain causation in terms of exploitation, class structure or state apparatus – suggesting the ‘logical impasse’.

What is provided in Foucault’s work is a history of the present, ‘a genealogical analysis of the forms of rationality and techniques of power constitutive of the present’ (Smart 2002:127). The form of the exercise of power and how it has changed is the basis for Foucault’s concept of power. From this basis Foucault has described a shift from the predominance of ‘sovereignty-law-repression to diffusion of subtle and economic forms of power exercised over individuals and populations’ (Smart 2002:127). Arguably it is only by the construction of an alternative approach to examining the exercise of power that this shift could be recognized. Rather than the problem of the state providing the focus, Foucault focuses on the modern forms of authority. It is through an analysis of techniques, tactics, procedures, practices that constitute the exercise of power, that the question of the modern state is addressed (Smart 2002:130). In this way Foucault encourages critical investigations of Information systems to engage in political philosophy.

Poulantzas (1978:149) asks if power is always immanent as Foucault suggests, ‘why should there be resistance?’. This concern was also raised by Habermas (1984 cited Brooke 2002:55) who saw Foucault’s conceptualization as presenting individuals ‘as inevitable ‘dupes’ in a network of anonymous regimes and yet nowhere does his genealogical analysis provide any justification for resistance to authority as opposed to adaptation’. For Foucault (1968) the art of government involves employing tactics not laws, (though it may use laws as tactics), continually redefining what is within the competence of the state, and what is not. Foucault argues that resistances cause ruptures that allow change in relations, they are not doomed to defeat (Foucault 1979:75). It is not an entirely satisfactory answer because it doesn’t address what is at stake in struggles and contests, what can be gained or lost. This will be revisited in section 2.6.

2.5 The Political Context

Locating power in situated action, Foucault casts each situation in a different set of historical circumstances and transformations – critical events. Empirical work conducted by Doolin (2004) placed the problematic of resistance in the context of larger political policy changes in
New Zealand, bringing to the surface otherwise hidden resistances. Policy, Prunty (1984:5) explains, serves to highlight the issues of power, control, legitimacy, privilege, equity, justice, and above all, values so embedded in the concept of policy. Corbitt and Thanasankit (2002) provided empirical support for this view when investigating various national policy directions in support of eCommerce: Concepts such as power, control, legitimacy, privilege, justice and equity affect the perceptions and ideology underpinning the policy, and the perceptions of its meanings of those to whom the policy is directed (2002:42). Policies and politics are intertwined (Corbitt, 1995). Indicated by Corbitt and Thanasankit’s (2002) study is that the policy process directs the thrust of decisions, tying decision making relating to deploy information systems and decisions to adoption of information systems to the political process. The dynamic nature of set of relationships which translate policy into practice, as action, is suggested. Locating the political context for Information Systems deployment within policy implementation as the site of situated action is suggested by Foucault but has not been explored in the literature.

Assuming a Foucauldian perspective, Ball (1990:3) defines policies as ‘the operational statements of values’, and the authoritative allocation of values (Kogan, 1975:55 in Ball, 1990:3). Ball (1990) argues that rather than a response to a community concern, the problems framed in policy are created or given shape in the policy proposals that are offered up as solutions (Ball 1990, Bacchi, 2000:48). Bacchi (1999) takes a similar view, describing problems as representations of issues and the effects of that representation as the area of interest for policy analysis. Ball (1993) refers to policy as discourse, taking its meaning from the Foucauldian sense as a structure of regulated practice, in which policy plays a role in setting the tone for the dialogue between society and those in powerful positions. Ball (1990, 1993) suggests power relations are created through the use of discourse, where ‘discourse represents meaning and social relationships’ (Peszynski and Corbitt, 2006:329). Policy as the medium through which social relationships are defined relates to agency and is conceptualized by Ball (1993) as policy as text. Policy discourses produce the ‘framework of sense and obviousness’ (Ball, 1993:11) in which it is possible to talk about such things as managing healthcare, providing the ‘right’ treatment, patient choice, market efficiencies. It has the affect of constraining how we think about problems and solutions by deriding or invalidating alternatives (Ball, 1990, 1993). Policy
texts are set within these frameworks but allow for interpretation which can affect implementation (Ball, 1993:11).

Lingard (1993) demonstrated the means by which the problem of education in Australia was redefined as an economic problem, placing education within the jurisdictional boundaries of the Federal Government in the new market led economy. Lingard (1996) highlights that policy analysis should also attempt to identify who is trying to legitimate their power and position through the policy process. Policies problems should be recognized as value laden, and the policy solutions offered detail the political transfer being proposed. Doolin and Lowe (1999) recognized that information systems define the legitimate documentation which determines how problems can be framed, and therefore which solutions can be applied. When problems are framed in micro economic terms solutions that attempt to address cost will be suggested (Doolin and McLeod 2005, Ozga, 1995). From Ball’s (1990, 1993) perspective, reforms and restructuring efforts represent an effort to reshape and change social values, rather than a response to community pressure, suggesting the creation of discursive space for action through policy.

Policies posit a ‘restructuring, redistribution and disruption of power relations so that different people can and cannot do different things’ (Ball, 1993:13). Discourses are about what can be said, and thought, and also about who can speak, when, where and with what authority (Ball, 1990:17). Discourses are more usefully conceived as ‘a multiplicity of discursive elements that can come into play in various strategies’ (Foucault 1979:100). Variant and different affects of discourse result from strategies which employ selective discursive elements and which position and favour different speakers (Foucault 1979). Ball (1995) describes discursive elements as ‘policy tools’ which combine to inform a larger discourse referred to as a ‘policy technology’ which is deployed to create a climate for change. …discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power: it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. (Foucault 1979:100). Discourse joins knowledge to power, it makes power possible: ‘It is in discourse that power and knowledge are joined together’ (Foucault 1979:100). However, discourse can provide
legitimacy to previously unchallenged discursive elements which can be used in opposing strategies, it can expose a lack of knowledge and position others to become expert and assume more powerful positions (Foucault 1979:102). For Ball (1993) the state is subjugated through the limits that discourse places on the possibilities of interpretation of policy, with power exercised through the production of knowledge. The difficulty experienced in determining the outcome of policy initiatives is associated with the difficulty of translating ideas into practice, a process which is subject to interpretation and recontextualisation (Ball 1990, 1993, 1994). From Ball’s perspective, assuming responsibility for directing social values via policy, the government must often accept a negotiated position. This position is not the end point. In this way the history of ideas can be viewed as the history of the present.

The role Ball (1990, 1993, 1994) ascribed to the state was criticized by Ozga (1990, 1987), Hatcher and Troyna (1994) and Henry (1993), who say the role is too limited with the emphasis on Government rather than a broader global view of capitalism. More recently the foundation for Ball’s discursive polity has been questioned by advocates of a ‘network society’. Hajer and Wagenaar (2003) assert that societies in developed countries are going through radical social change which requires a different type of democracy with a different type of analysis. They refer to a ‘network society’ that creates ‘new actors, new sites and new themes’ (Hajer and Wagenaar 2003:6) which requires a new analysis to understand it. Network governance has been described as an emergent form in which the ‘spatialized state coordinates political and economic relations between multiple public and private actors transnationally while linked to localized networked partnerships that deliver services’ (Ball, 2007: Rhodes, 1997 cited Blackmore 2011:446). This has been charged with lessening the impact of ‘the state’ and ideology in general on policy solutions: ‘solutions for pressing problems transgress the sovereignty of specific polities’ (Hajer 2003:175). Hajer and Wegenaar (2003) argue that the assumed political context of policy analysis such as Balls (1990, 1993, 1994, 2003) has at least three defining elements that can be labeled (1) polity, (2) knowledge and (3) intervention. ‘The stable political order is assumed to be there. Second, a way of producing knowledge that is for politics but in itself not political but scientific. Third, intervention, a problem-orientation, culminates in notions of meaningful policy intervention to change a given course of events’ (Hajer 2003:182). Hajer (2003:182) suggests that the metaphor of the ‘network society’ (Castells 1996) implies that the means for shaping of
cultural values, and adherence to polity has changed. Hajer (2003) argues that the relationship between science and society has changed, scientific expertise is now negotiated rather than simply accepted, and the changing role of government means it is not the sole actor to intervene in policy making. Albrow (1996) and Considine (2003) made a similar charge. Empirical work completed by Considine (2003) suggests network governance as a meaningful concept while finding that ‘The most dominant orientation for the vast majority of officials relates to corporate management’ (Considine 2003:139). Hajer (2003:183) and Hajer and Wagenaar (2003) provide an explanation for this suggesting that while the institutional structures have not disappeared, their legitimacy is constrained: ‘the classical-modernist institutions lose the implicit support and assisting power of aligning socio-economic processes and cultural adherences’. Analytical work by Blackmore (2011:446) found a changing government mode where multiple modes of doing and thinking about government coexist, being constantly negotiated and contested. Policy then is no longer the outcome of politics, but politics results as policy initiatives are made public (Hajer 2003:183). Despite changing ideas about the state and its sphere of influence, the endeavor to uncover the exercise of power, that is the way people are governed and made governable, led Hajer (2003) and Hajer and Versteeg (2005:346) to conclude that ‘any particular governance network will first have to develop a shared discourse and ‘set the stage’, that is, work out a script for resolving conflict and develop its logic of appropriateness to understand the dynamics of governance network’. The problem of the modern state and the way in which it governs continues to lend itself to a discursive analysis. The utility of Ball’s (1993, 2003) concept of policy as discourse is not diminished by the notion of a network society, however, it suggests focusing on the more mundane tactics and practices situated in the changing role of Government.

The nature of political action in policy continues to require investigation because in choosing the social problems to tackle or ignore and solutions to consider or reject, the influence of the political sphere in deploying its resources can affect outcomes. A political lens provides an understanding of the inclusion of poor information sharing in framing the problem of delivering public goods such as health, and suggestions of information systems as part of the solution.

2.6 The Connection between Expert Knowledge and Reward
What is to be gained by achieving policy objectives? What is at stake in contests? Despite Foucault’s focus on the mutually dependent relationship of knowledge and power, and his assertion that the art of Government involves employing tactics to redefine what is within the competence of the state, the connection between expert knowledge and reward is not fully drawn. Bourdieu (1984:93) understands this connection as the impenetrability of expert knowledge which authorizes the qualified to speak with authority about what constitutes the field, providing cultural authority. This authority allows for framing of problems and proposal of potential solutions. Abbott (1988:59) describes professions as bound to a set of tasks by ties of jurisdiction, and the strengths and weaknesses of these ties being established in the processes of actual professional work.

Bourdieu’s (1977) focus on the visible social world of practice and his attempts to construct a theoretical model of social practice provide a framework for understanding how actors perpetuate existing power relationships. In this way Bourdieu suggests that the status quo represents a struggle. Bourdieu presents practice as the product of processes which participants are only partially conscious of, which are shaped from learning, and which allow participants to ‘know without knowing’ the right thing to do (Bourdieu, 1990:62). He uses the concepts of the field and of the habitus to model practice. A field is a structured system of social positions the nature of which defines the situation for their occupants (Jenkins, 2002:85). Power relations determine the internal structure of the field. The point at which the field can no longer affect practice is what is at stake in the struggles which take place in the field – contests arise when the influence of the actor with authority to speak to impact upon the taken-for-granted behaviour of others is waning. Bourdieu (1984) recognizes that the more technologically complex and socially differentiated the society, the more fields there will be. Social positions and social relationships ‘whether relationships of domination, subordination, or equivalence to each other, are determined by virtue of the access they afford to the goods or resources at stake in the field’ (Jenkins, 2002:85). The capital goods in the field take the form of: 1) economic capital, 2) social capital (valued relationships), 3) cultural capital (legitimate knowledge), and 4) symbolic capital (prestige and social honour) (Bourdieu, 1990:229).
Bourdieu’s (1984) elaboration of the structure of the scientific field as imposing upon its participants a habitus that has tacit interest or investment in objectivity, insists that what matters most is discourse itself. Discursive legitimacy supported by the production of knowledge is regarded by professions as a necessary means for accumulating symbolic capital (Larson, 1990:38). Bourdieu (1984) refers to the authority to speak as symbolic capital because it accrues to initial investment and can be accumulated. All benefits and rewards become contingent with respect to the specific reward expected in scientific fields – the authority to speak (Larson, 1990:34). Authority to speak and legitimacy have been conceptualized as interchangeable concepts (Vaughan, 2008: Moi, 1991). Professionals in societies which value specialized expert knowledge (cultural capital) and which are structurally unequal, can expect to benefit in the form of market opportunities (economic capital) and status (authority to speak or symbolic capital) and work privileges (social capital). Bourdieu (1984) posits that structures change over time and space as actors pursue cultural distinctions (Bourdieu, 1984:96). However, while structures evolve, positions in the hierarchy remain largely unchanged. Practices serve to reify social structure, the intent is to hold actors in self-generating and self-perpetuating social hierarchies (Jenkins 2002: Kvasny and Truex 2000). Bourdieu's approach to the study of practice emphasizes the constant struggle at the boundaries that demarcate social space (Lounsbury & Ventresca, 2003).

Bourdieu provides a view of the relationship between the expert knowledge of administrators and of medical professions and the rewards that can be gleaned from that expert knowledge. Bourdieu (1984) provides an understanding of the desire to maintain the status quo and resist practice change in spite of financial and other incentives offered in support of reform. Beyond a shift in power relations, Bourdieu offers a richer of understanding of What is to be gained by achieving policy objectives? and What is at stake in contests?, the authority to speak.

2.7 Conceptual Lens

This review has identified diverse definitions and varying understandings of the nature of power exist in health policy studies and information systems research. It suggests that to gain an understanding of the limited role afforded information system in the Australia healthcare setting efforts should be directed towards an analysis of power. A concept of power which seeks out the
obvious and hidden aims of renegotiated information systems through the lens of broad national reforms I argue will address the current limited understanding of where information systems fit in the political landscape. The problem of how to conceptualize power and relate power to notions like discourse and how to integrate these ideas of power into a conceptual framework for policy analysis will be responded to by the conceptual framework outlined here which allows for the exercise of power to be viewed as constituent in health practices. The literature suggests a concept of power which is not possessed but is the capacity for action residing in social relations, which can be exercised in the spaces for action made possible during periods of discursive transition. The periods of discursive transition are understood as the period of meaning making constituent in a health policy process which is itself constituent of power relations and is involved in governance and advocacy and tied to polity, knowledge and intervention. The extent to which renegotiated information systems are reflective of attempts to circumvent power redistribution is an area unexplored in the research literature.

This study attempts to address that gap by contributing an analysis of the systemization of information which focuses on the neglected resistances in the history of healthcare in order to provide insight into the unresolved disputes that may be impacting current adoption behavior. The study will focus on the discursive spaces for action within which acts of power and resistance can unfold rather than the actions of power and resistance. The formation of discursive spaces for action is of primary concern. This should enrich understandings of the political landscape in which eHealth is operating. The approach taken in this thesis is to improve understanding of the move to reform healthcare through increased access to data in the form of eHealth. It suggests evaluating these reforms within the context of wider reforms.

The modest intent of this study, to investigate the slow adoption of health informatics in the Australian setting, avoids the more ambitious aims encouraged by a Foucauldian analysis, which would attempt an understanding of the motivations and means of systematising information in healthcare. As a means of making sense of the possibilities, and responses to, the role of information systems within policy initiatives, this study will attempt to relate information system deployment to tactics of governmentality. Concentrating on understanding the practice of systematisation of information in healthcare, the tactics which underpin the taken-for-granted
‘manageability’ of information in healthcare and its relationship to the history of ideas, I suggest, will help to provide an interpretative framework in which the motivations and responses to information system can be examined. The conceptual framework outlined in this chapter informs the analytical framework described in Chapter 3.
Chapter 3

Methodology

3.1 Introduction

The research approach used in this study is consistent with a critical interpretivist methodological position (Putnam 1983, Doolin 1998). This chapter discusses the methodology and analytical framework used in this study of the systemization of information in the Australian health care setting. The analytical framework is informed by the conceptual framework outlined in Chapter 2 which is in turn informed by the literature of health policy studies and IS implementation studies and theoretical debates over the nature of power and politics in the policy process and IS implementations. A critical stance in relation to the role that health information systems play in supporting institutional arrangements and power relations in healthcare is adopted (Doolin and McLeod 2005). A Foucauldian perspective is used to inform the critical interpretation and analysis. This study mobilizes a Foucauldian conception of power to understand the resistance to, and implementation of, health information systems in Australia. This study of policy deployment will be concerned to address the formation and effect of a ‘taken-for-granted’ (Foucault 1979) role of information systems in the delivery of healthcare. This will provide an opportunity to compare the impact of challenges to policy implementation with existing theory, and to contribute to explanations of resistance to information systems adoption.

This chapter provides justification for the research approach. The chapter will begin with a discussion of the critical interpretivist approach, followed by a discussion of a research approach. Section 3.3 describes the method of data collection for the study. Ethical questions are raised in section 3.4. The chapter concludes by describing the analytical framework used in the study.
3.2 Research Approach

This study of power and politics in the systemization of health information draws on a Foucauldian concept of power rooted in critical philosophy. Orlikowski and Baroudi (1991:19/21) describe the central idea of critical theory as, ‘Social reality is historically constituted and … knowledge is grounded in social and historical practices’. For Foucault this focused efforts on revealing discursive practices giving rise to knowledge (Smart 2002:53). This suggested that to understand health information systems it is necessary to study the particular contexts within which the ideas relating to the deployment of health information systems were proposed. In this study, resistance is not represented in the interaction between IS and user but in the ideas which led to IS being proposed as a potential solution to the problem of delivering healthcare. This does not immediately rule out the use of interpretive research in favour of critical research. ‘Interpretive research involves the study of social practices in the context in which they occur’ (Doolin and McLeod 2005:245), and has an established place in IS research (Leonardi 2008, Doolin and McLeod 2005, Walsham 1993, Myers 1997), highlighting the general acceptance of the contextualist approach. Doolin and McLeod (2005:246) describe the primary purpose of interpretive research as offering an account or interpretation of and for human conduct which takes it beyond describing the scene to providing a contextualized understanding. Health policy analysis studies’ strong history in comparative studies seeking to understand the contextual differences between national policy approaches has provided interpretative research methods a secure foothold (Fischer, Miller, Sidney 2007). The task of an interpretivist researcher interested in power is to make sense of hidden intentions and seemingly perplexing actions (Silva 2007:169). Myers and Klein (2011:31) suggest that the attraction of the interpretative method is that it is ‘logically more coherent’ than that of critical research. As noted in Chapter 2, critical theory is not prescriptive with regard to techniques of investigation (Morrow and Brown 1994). Despite the focus on context, as discussed in Chapter 1 and 2, limited attention has been paid to power and politics in health policy studies and information systems research.

A view of interpretative and critical philosophies as separate is expressed by Orlikoski and Baroudi (1991), and is echoed in Walsham’s (1993) and Boje’s (2001) caution that a critical
interpretative approach must be attentive to the very different emphases of the approaches - interpretative focus on description and understanding, while critical theory has as its focus emancipation and the importance of values. Within the interpretive approach to IS, some authors have proposed Critical Theory as an alternative for guiding researchers interested in investigating power (Silva 2007). Doolin and McLeod (2005) suggest some middle ground between the critical and interpretative approaches, arguing for critical interpretivism. Rather than viewing the approaches as having separate research philosophies, the overlaps between approaches are emphasized. Myers and Klein (2011:32) acknowledge the principle of suspicion for interpretive research ‘goes beyond pure interpretivism because it points the researcher to ‘read’ the social world behind the words of the actors, a social world which is characterized by power structures, vested interests and limited resources to meet the goals of various actors who construct and enact this social world’ (Klein and Myers 1999:78’). Doolin and McLeod (2005:246) call for a grounding of critical research in empirical work, suggesting ‘empirical data are the results of interpretation, and the generation of empirically grounded, local understandings is an essential component for critical research’. Recognizing interpretive IS research as having ‘detailed empirical knowledge of organizational activity that is local and contextualized, can contribute much to such an expanded conception of the critical management research agenda’ (Doolin and McLeod 2005:247).

Interpretivism offers suggestions for techniques of investigation which are not prescribed in critical research, and which have a secure footing in both Information Systems research and health policy studies. Critical theory provides a means of dealing with the element of transformation (Myers and Klein 2011), it focuses on the opposition, conflict and contradiction providing a way of understanding resistance, seeking to eliminate the causes of these inconsistencies (Orlikowski and Baroudi, 1991), and as discussed in chapters 1 and 2, it concerns itself with issues of power and supports a conception of power as complex, multilayered and fluid necessary for this study. The critical interpretivist perspective deconstructs the taken-for-granted assumptions inherent in the status quo, and connects local understandings or interpretations to broader considerations of social power and control, asking how these came to be shaped and for whose benefit (Doolin and McLeod 2005:248). The critical interpretative perspective suggests qualitative techniques in order to gain an understanding of: 1) how the
rendering of health information systems into particular discursive frames transforms the types of jurisdictions health information systems are subject to, 2) how the rendering of health information systems into particular discursive frames implicates information systems in the governance of ‘the conduct and subjectivity of organizational participants’ (Doolin and McLeod 2005:249), 3) the perspective of participants in interpreting and renegotiating policy, and 4) the perspective of participants in interpreting and renegotiating the role assumed by information systems in support of reform.

The achievement of critical interpretivism in research is grounded in three principles:

(i) the construction of detailed, local and situated empirical interpretation:
(ii) a reflective approach that reveals and disrupts the assumptions and certainties that reinforce the status quo in organizations: and
(iii) the connection of interpretation to broader considerations of power and control (Doolin and McLeod 2005:248).

Alvesson and Deetz (2000) suggest that to be critical, interpretive Information Systems research must extend into the larger historical, economic, ideological, political and cultural context - the particular contexts within which the ideas relating to the deployment of health information systems were proposed. This study aims to achieve an understanding of the particular contexts, while adhering to the principles of critical interpretivism, by combining local situated studies with a wider societal and historical perspective.

A three-layer approach is adopted (Klecun, 2005:389) which places local strategies (practitioners perspective – ‘mezzo layer’) and individual projects (‘micro layer’), under the umbrella of Australian health policy and broader national policy aims (‘macro layer’), focusing on critical events in the history of health policy in Australia: ‘The forces operating in history are not controlled by destiny or regulative mechanisms, but rather respond to haphazard conflicts’ (Foucault 1977:154), a critical event is seen not as the cause of change but as the usurpation of power. From the macro perspective the analysis focuses on the health policy in relation to power relations and the employment of the systemization of information in reform. Epistemologization as a type of historical analysis is outlined by Foucault (1977:190) as located at ‘the point of
cleavage between discursive formations defined by their positivity and epistemological figures that are not necessarily all sciences’ – the analysis attempts to reveal discursive practices giving rise to knowledge (Smart 2002:53) - knowledge which can create a force for change (Kemp, 2007:48/50). The macro layer for this study encompassed periods in Australia’s health policy history which involved a significant change in the role of government - periods of major reform when ideas about the realm of central control in the management of healthcare created a perceived need for a national approach to determining the direction of healthcare, periods identified in seminal articles. The mezzo level concentrated on local strategies and initiatives from a practitioners’ perspective focusing on the language and perceptions of decision makers and participants to gain insight into understandings or interpretations of reforms involving information systems. The micro level comprised the study of a few individual implementations - Medibank billing system (1970’s) and Casemix (1990’s) - and eHealth systems (current) which have a subjective existence. These localized systems and the negotiations involving their implementation positions the focus of this study of power at sites of resistance (Foucault 1982a:780), and represents the point of reference for practitioner participants.

Table 3.1 ICT deployed in support of reform 1920 - present

<table>
<thead>
<tr>
<th>Date range</th>
<th>Major reform attempted</th>
<th>Information system deployed</th>
<th>Practice knowledge area used to shape interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920’s – Chapter 4</td>
<td>Establishment of a Commonwealth department of health</td>
<td>Disease Registers Standardised prescription forms</td>
<td>Preventative Health Curative Health</td>
</tr>
<tr>
<td>1940’s – Chapter 4</td>
<td>Nationalisation of medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970’s – Chapter 4</td>
<td>Universal Insurance coverage</td>
<td>Medibank billing system Casemix IS</td>
<td>Financial management Hospital/Acute care Patient relationship</td>
</tr>
<tr>
<td>1990’s – Chapter 5</td>
<td>Publicly funded private Health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010 – Chapter 6</td>
<td>Patient responsible healthcare</td>
<td>eHealth</td>
<td></td>
</tr>
</tbody>
</table>
3.4 Data Collection Method

The qualitative technique used included semi-structured interviews. ‘Open-response questions to obtain data of member meanings – how individuals conceive their world and how they explain or ‘make sense’ of the important events in their lives’ (McMillan and Schumacher, 1993 cited Leedy, 1997:159). Sample Questions are detailed in Appendix A. A total of 19 face-to-face, one-on-one interviews are presented in this study (over 30 interviews were conducted – in the case of the 11 interviews not presented, the researcher discarded a number based on relevance, in some cases the participant withdrew from the study, although their input still informed the analysis. The researcher acknowledges that the process of conducting face to face in depth interviews informed the researcher’s understanding of the problem of delivering healthcare. Despite some participants later withdrawing from the study, the impact of their descriptions and understandings of the process of translating policy into practice would have continued to inform the analyses undertaken simply because they informed the researcher’s understanding). This method has been described as the ‘richest medium because it provides immediate feedback so that interpretation can be checked. It also provides multiple cues via body language and tone of voice’ (Daft and Lengel (1986:560). The interviews were conducted with participants outlined in Table 3.2 below. The participants were mainly senior managers in health organization and those involved in decision making positions with respect to health information systems. The researcher accepted membership to the executive committee of the Health Informatics Society of Australia, Victorian division, and assisted in the 2009 annual conference, gaining access to prospective participants. Interviews conducted with participants in past installations were located by reviewing literature which identified their involvement – e.g. David Tow was contacted following a reference in ‘The Making of Medibank’ (1993) to a report he wrote on behalf of the Australian Medical Association in the 1970’s: Christine MacDonald was approached as the co-author of ‘The Making of Medicare’. Professor Len Gray and Dr Anna Howe were contacted because they co-authored articles concerning Casemix in the mid 1990’s with Professor Stephen Duckett who was widely regarded in the literature as the architect of Casemix in Victoria. A good representation of clinical and administrative staff was considered particularly important given the potential for differences in perspective. Each participant was allocated a unique
identifier made up of a code and number e.g. MR1 relates to medical respondent 1. The code is used in Chapters 4, 5, 6 and 7 to readily identify the perspective being provided by the interview quote drawn on. Interviewees were chosen because of the positions they held in organizations or their involvement in the negotiations involving health information systems. It was felt that senior managers (both clinical and administrative) are engaged in reflecting on the policy process as part of their professional activity, providing required perspective. All interviews were recorded and transcribed.

The researcher used the ‘reflection-on experience’ technique (Boud 1993, Schön 1987, Yoong 1999), which involves the trainee [interviewer] revisiting the experience [first and subsequent interviews]… The interviewer re-evaluates the experience, makes connections with prior experience, and plans the appropriate strategy to deal with similar events in the future [in this case, modifying the questions in order to achieve the appropriate answer to the research question, or further identify issues that arose in the first interview] (Yoong 1999:94). As a result the approach to the interview, and emphasis of questions, was modified slightly for each interview. The interview questions were in the form of: What are your expectations of a well performing Australian healthcare system? Is the current system meeting your expectations? If not, why not? Who has the most accurate picture of the performance of the health system? What role do shared integrated information systems play in healthcare? What role should they play? Why have Medibank billing/Casemix/Health connect/eHealth systems experienced implementation delays? How has clinical practice changed as a result of the implementation of information systems? What are your expectations of a well performing health Information System? Will your expectations be met? If not, why not? The questions changed to reflect the observations made by participants. Each interview lasted between sixty and ninety minutes.

3.4.1 Ethical concerns
All participants approached to participate in this study were given a consent form and plain language statement. This informed participants of the objectives of the study and addressed any ethical issues. Participants were asked if they would prefer to be anonymous. All participants gave permission to having their names published within the thesis. Participants were asked if the researcher could tape record the interviews, which would then be transcribed. The researcher
offered all participants the opportunity to review a copy of the transcript. When requested, the researcher sent copies of the transcribed interview to the participant. This allowed participants the opportunity to change their transcript if desired, including typographical errors and errors by the researcher misinterpreting the recording of the interview.

Table 3.2 Practitioner participants selected for this study.

<table>
<thead>
<tr>
<th>Code Used</th>
<th>Name</th>
<th>Position at time of interview</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA1</td>
<td>Ms Megan Buick</td>
<td>Primary Healthcare Liaison, Program Consultant</td>
<td>General Practice Victoria</td>
</tr>
<tr>
<td>MA2</td>
<td>Ms Jan Begg</td>
<td>Director</td>
<td>Royal District Nursing Service, Victoria</td>
</tr>
<tr>
<td>MA3</td>
<td>Mr. Bill Newton</td>
<td>Chief Executive Officer</td>
<td>General Practice Victoria</td>
</tr>
<tr>
<td>MA4</td>
<td>Mr. Trevor Fisher</td>
<td>Chief Executive Officer</td>
<td>Victorian Association of Healthcare</td>
</tr>
<tr>
<td>MA5</td>
<td>Mr. Zac Gruveski</td>
<td>Chief Financial Officer</td>
<td>Royal Women’s Hospital, Victoria</td>
</tr>
<tr>
<td>MR1</td>
<td>Dr Nick Buckmaster</td>
<td>Director of General Medicine and Chronic Disease</td>
<td>Gold Coast Health Service District, Queensland</td>
</tr>
<tr>
<td>MR2</td>
<td>Dr Tim Woodruff</td>
<td>Vice President and Rheumatologist</td>
<td>Doctors Reform Commission</td>
</tr>
<tr>
<td>MR3</td>
<td>Dr Guiliana Antolovich</td>
<td>Pediatric Lead public children’s hospital</td>
<td>Royal Children’s Hospital Melbourne, Victoria</td>
</tr>
<tr>
<td>MR4</td>
<td>Dr Peter Davoren</td>
<td>Clinical Director of Diabetes and Endocrinology and Associate Professor</td>
<td>Gold coast hospital/ Griffith University, Queensland</td>
</tr>
<tr>
<td>MR5</td>
<td>Dr Terry Hannan</td>
<td>President of Australian College of Health Informatics and Clinician</td>
<td>University of Tasmania Department of Medicine</td>
</tr>
<tr>
<td>CR1</td>
<td>Professor Michael Georgeff</td>
<td>Chief Executive Office</td>
<td>Precedence Health Care (a health informatics solutions provider), Victoria</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CR2</td>
<td>Mr. Adam McLeod</td>
<td>eHealth and Business Development Portfolio Manager</td>
<td>Melbourne East Division of GP’s – lead implementation site for the Personally Controlled Electronic Health Record</td>
</tr>
<tr>
<td>CR3</td>
<td>Mr. Peter Williams</td>
<td>General Manager Implementation</td>
<td>National eHealth Transition Authority (NEHTA)</td>
</tr>
<tr>
<td>CR4</td>
<td>Mr. Vincent Price</td>
<td>Health consultant to the government</td>
<td>Victorian Department of Health</td>
</tr>
<tr>
<td>CR5</td>
<td>Mr. Jim Swinden</td>
<td>Director Health Consultancy and former hospital administrator</td>
<td>Aspex Consulting, Victoria</td>
</tr>
<tr>
<td>PA1</td>
<td>Ms Christine MacDonald</td>
<td>Policy analyst and Co-author The Making of Medibank</td>
<td>General Practice Divisions</td>
</tr>
<tr>
<td>PA2</td>
<td>Dr Anna Howe</td>
<td>Policy analyst and Consultant Gerontologist</td>
<td>Self employed consultant</td>
</tr>
<tr>
<td>TOW</td>
<td>Mr. David Tow</td>
<td>Former information systems consultant for the Australia Medical Association</td>
<td>Retired, New South Wales</td>
</tr>
</tbody>
</table>

MA = Medical Administration  
MR = Medical Respondent  
CR = Corporate Respondent
3.4.2 Data selection

The data selected, and explanation of appropriateness for triangulation in providing an accurate representation of the context for each localized implementation is detailed in the chapter it relates to: for example, a discussion of the interview data selected for the study of Casemix is detailed in Chapter 5. The focus of this study of power and politics is on the relationship between information system deployment and tactics of governmentality. In accounts of governmentality, intelligibility not exhaustiveness is the key (Cousins and Hussain 1984:4). What is sought is not an exhaustiveness of evidence but an intelligibility of problematisations: what counts as adequate ‘evidence’ tends to differ here from reactive accounts of ‘policy’ (Osborne 1997:175, Osborne 2003).

The other source of data collection was in the form of documents, which included collecting archive material from the National Archives of Australia relating to the introduction of the Medibank billing system. The archive material had been deposited by Richard Scotton upon completion of his research book ‘The Making of Medibank’ (1993), co-authored by Christine MacDonal who agreed to participate in this study. The archive material contained memo’s and internal documents relating to Medibank ranging from commissioned reports concerning the billing system to memo’s of an informal nature between the Health minister and the Prime Minister relating to negotiations concerning adoption of the billing system. The Medical Journal of Australia and the British Medical Journal archives, and the National Library of Australia, supplied documents relating to Cumpston and Cilento dating from the 1920’s and 1940’s which are used in Chapter 4. A request for documents relating to the introduction of Casemix in Victoria was made via the Freedom of Information Act (1982). One document was recovered eight months after the initial request and is described in Chapter 5. Publicly available policy discussion documents, commissioned reports, information such as books reporting the history of the healthcare policy, conference and journal papers relating to national policy directions and health information systems were also drawn on. The benefits of collecting documents as a method of data collection include the observation that they are:

- stable, and can be reviewed repeatedly;
unobtrusive, as they are not created by members of the organization for the purpose of the research;
exact, as the information contains exact names, references and details of events;
broad in coverage, spanning a long period of time: and
able to corroborate and augment details given in interviews.
(Yin 1994:80)

Access to these documents validated and verified participant responses, and provided a richer understanding of context. Essentially, the nature of interpretative analysis involves the researcher interpreting the narratives provided by the participants interviewed. It is acknowledged that if other researchers were replicating this study, different interpretations may be obtained.

3.5 Framework for Analysis

The data analysis is guided by a Foucauldian critical perspective. The researcher acknowledges (but ignores) Klecun (2005:394) call to follow the hermeneutic circle of understanding (Gadamer 1976) when conducting the analysis of documents and empirical research. The hermeneutic circle, which ‘expresses the need to understand the parts of a text through the understanding of the whole, while the understanding of the whole is determined by our understanding of its parts’ (Klecun 2005:395), places the analytical emphasis with meaning located in socio-historical and cultural practices and texts. While the location for analysis, and the understanding that alternate interpretations of the data are possible implies its utility to this study, a Foucauldian analysis is distinguished from hermeneutics ‘in that there is no conception of a deep or ultimate truth awaiting recovery’ (Smart, 2002:16).

The aim of a Foucauldian analysis of data becomes to write a policy history not of the implementation of information systems but of the practice of systemizing information. Ideas about information as collectible, as representative of positive facts as necessary have their point of formation in diffused practices. An attempt is made to reveal discursive practices giving rise to knowledge (Smart 2002:53). A study of history as a history of the present reveals to the researcher the origin of self-evident understandings of concepts such as health and information, showing how at certain moments they became a principle component in our understanding of how to frame problems and offer solutions, how the accepted value placed on health services
comes to be. It is ‘the history of problematizations, that is the history of the way in which things become a problem’, that provides the analytical focus (Foucault 1997:414). Through a policy lens, a Foucauldian (1979, 1981) approach aims to identify the transformations which make transition from policy to practice possible.

In order to understand the motivation of health policy solutions which utilize information systems, the possibilities of health information to affect the ‘objects, operations, concepts and theoretical options’ (Foucault, 1979:56), to affect the discourse of healthcare, the set of conditions which were present at a moment in time making it possible for transformation to occur is the focus. An analysis of the transformations of the discursive formation of healthcare – the mutation of the discursive space or the change environment for action – involves identifying;

1) ‘the displacement of boundaries which define the field of possible objects’ (from the art of medicine to its scientification through to the management of risk in relation to health and its inclusion of the sphere of wellbeing)

2) ‘the new position and role occupied by the speaking subject in discourse’ (from trusted family doctor to profit motivated provider of health services, from patient to empowered consumer, from information as collectible and capable of making disease manageable to information as capable of freeing patients from the imbalanced doctor/patient relationship).

3) ‘a new mode of functioning of language with respect to objects’ (information as a conduit metaphor applied to biology enables a concept of ‘genetic information’ and the ‘genetic makeup’ of humans to be interpreted as information)

4) ‘a new form of localization and circulation of discourse within society’ (medical research has moved from the domain of individual researchers to teams of scientists changing the way clinical discourse is ‘formulated, amassed, conserved or contested’)

Foucault (1979:57).

The qualitative data collected in this study will be analyzed against the 4 sets of conditions identified above, to indicate the transformation of discourse and to identify the discursive space for action. The three layers of data collected will be analyzed against these conditions. The political system is one which provides a possible object for a particular discourse – transforming
the system of formation of health information systems through administrative recordings, establishment of archives, statistical groupings. It is the conditions of the existence of discourse that is of relevance: what research areas are encouraged, which analytical and thought processes are rewarded, who is granted authority to speak. The maneuvers and negotiations which shape the discursive space and which occur within this discursive space provide the focus when analyzing the policy documents and empirical research. The genealogical analysis undertaken in this thesis follows the construction of two core ideas identified in the literature to have shaped the Australian healthcare setting: 1) healthcare is manageable, and 2) quality healthcare is deliverable through the ‘right’ practice. The participant’s perceptions of the possibilities or constraints of information systems, interpretation of the change environment, and the descriptions of the negotiations and renegotiations of information systems will highlight the ideas which have diffused into practice, and those ideas rejected.

Changes to the episteme, the positioning of expert knowledge, can impact simultaneously on several discursive formations, creating opportunities to reframe problems and solutions. The analytical importance is not placed on the typology of transformations, or the structural methods of its construction, but on the content of change. ‘The discontinuities, recurrences, unexpected backlashes between systems of knowledges are revealed by genealogical analysis’ (Dean 1994). It is the conditions of the existence of discourse that is of relevance, relating discourse to the practical field in which it is deployed to become self evident. The rules which came into affect so that all of the concepts, operations and theoretical options of a particular discourse are influenced, creating the taken-for-grantedness, is the focus. Therefore, the history of ideas – healthcare is manageable and quality healthcare is deliverable through the ‘right’ practice - must be ‘a descriptive analysis of the different transformations effectuated’, describing ‘the set of rules at a given period for a given society which define’ (Foucault 1991a:58-60):

1) ‘The limits and forms of appropriation’. Authority to speak on ‘affordable healthcare’ will be conferred on those groups deemed experts in economic management. Institutionalizing this relationship are practices including effectiveness studies and comparison studies which place ‘practice’ as the focus of causation in explanations of escalating expenditure costs, provided the information is not contested. The ability to
present research findings in a form deemed scientific controls the jurisdictional boundaries of discourse.

2) ‘The limits and forms of the sayable’. How is it possible to speak about healthcare – as a social justice issue or a manageable administrative service? How is it possible to speak about ‘best practice healthcare’? Medical science is the discursive domain assigned the descriptive science through research generation and ‘expert knowledge’, healthcare is the discursive domain assigned as matter for narrative treatment, determining the forms and limits of the sayable.

3) ‘The limits and forms of conservation’. How has it been made possible that health as a right of citizenship is an utterance that has disappeared, while equity, access and affordability are the utterances which have been put into circulation? Personalized medicine is an utterance which has been put into circulation, while community healthcare is an utterance which is disappearing.

4) ‘The limits and forms of memory as it appears in different discursive formations’. Measurable outputs provide a measure of effectiveness (positive facts are measured by numbers), preventing illness involves managing lifestyle risk factors, are recognized as valid utterances. Alternatives to the current biomedical model have been abandoned.

5) ‘The limits and forms of reactivation’. Preventive medicine has been reconstituted from its role in quarantine and immunization to include identification, classification and treatment of ‘risk factors’.

(Foucault 1991a:58-60).

Within the policy context, these rules describe the conditions under which the a) problems and solutions to healthcare are framed, b) the dialogue about problems and solutions are influenced, c) the solutions proposed are constrained by the framing of problems, and d) they determine the impact on practice. This study of the systemization of information considers periods of major reform as critical events in the history of health policy. Critical events indicate the transition from policy to practice, and the point at which the mutation of the discursive formation is contested – the discursive spaces for action. The focus on events in genealogical analysis seeks the singularity of events to discover the multiplicity of factors constitutive of an event (Smart 2002:58) – it seeks out the self-evident questioning explanations of necessity, and it exposes the
complex field of relations, connections, strategies and forces which precipitate the establishment of an event which in turn becomes self evident (Foucault 1981:77).

The history of health policy in Australia provides the analytical lens for this study. However, the focus of this thesis is the analysis of the systemization of information as a means of diffusing reform ideas into practice, rather than the historical analysis.

Health policy in Australia experienced two main ruptures, the first was more an ‘inflexion on the curve’ (Foucault, 1979:115) and occurred with the establishment of a Commonwealth health department and its attempts towards a nationalized health system, this period was characterized by a conceptualization of a centralized health system as vital to national security and prosperity, and the association of medical science with progress. The second rupture occurred in the 1970’s with the introduction of a universal health insurance scheme, when the role of government was expanded, and the influence of the medical profession waned, and equity was envisaged as access to healthcare. The current inflexion marks the passing from concern for social justice in healthcare to a relative tolerance towards profit motivated health provisioning, the conceptualization of competitive structures as essential and self responsibility for managing health as right.

The objects, operations, concepts and theoretical options which indicate the disruption to the discursive formation of healthcare – the point at which the possibility for policy to enter practice exists – will be examined by focusing on critical events and analyzing the qualitative data. The genealogy focuses on the distinctive characteristic and manifestation of events, on the ‘effect of haphazard conflicts … of relations of power and their unintended consequences … the objects of genealogical analysis are … more common forms of existence and knowledge’ (Foucault 1981:80, Smart 2002:59). It is anticipated that by focusing on the contests which relate specifically to the systemization of information, the diffused practices which represent the history of ideas which inform the possibilities of information systems in healthcare will be exposed. Analysis proceeds along two dimensions, a decomposition of ‘the processes constitutive of a particular event and a concomitant ‘construction of their external relations of intelligibility’ (Smart, 2002:58).
3.5.1 Analyzing relations to governmentality

Policy as discourse suggests that policies problems are value laden, and that the policy solutions offered detail the political transfer being proposed. A ‘regime of practices’ needs to be analysed, identifying tactics of governmentality involved in the production of truth. Ball (1993, 1998) encourages investigating policy ensembles, or collections of related policies, which ‘exercise power through a production of ‘truth’ and ‘knowledge’’ and provide the framework for the construction and resolution of policy issues (Ball, 1993:15). Lingard and Porter (1997) provides the practical beginnings for enquiry, encouraging viewing the expression of power relations in the policy setting in Australia through broad national reform agendas, in order to understand the legitimate role for government, the boundaries in which it operates, and strategies used to extend these boundaries - it is the tactics of government which make possible the continual definition and redefinition of what is within the competence of the state and what is not (Foucault 1991b:103).

The tactics used to alter discursive spaces to allow for a redefinition of the role of government is the suggested starting point for this study, with a focus on the economic domain. The concept of policy as discourse will be utilized to explore how social values are formed – how interests are formulated to create a change environment. The political policy tools which formulate the policy technology involved in creating ‘self-evident’ truths needs to be identified. Foucault’s understanding of discourse as providing the medium through which power relations create speaking subjects, is utilized as the analytical framework, allowing the many and varied parts of the policy process to be pulled apart to allow an explanation of how policy tools contribute to a political exchange and to reveal who benefits. The jurisdictional control of areas of expert knowledge - how it is created, influenced and maintained - will be of particular interest in order to allow an explanation of the role of policy in creating discursive spaces.

The concept of governmentality (introduced in Chapter 1 and Chapter 2), suggests an important analytical strategy to facilitate scrutiny of the ‘regime of practices’ involved in the production of
truths, is to identify the political policy tools which formulate the policy ensemble, or policy technology, involved in creating ‘self-evident’ truths. Foucault (1991b:103) emphasizes that ‘it is the tactics of government which make possible the continual definition and redefinition of what is within the competence of the state and what is not, the public versus the private, and so on: thus the state can only be understood in its survival and its limits on the basis of the general tactics of governmentality’. The starting point for analysis, across the layers of data collected, is the role identified for the state in the management of healthcare, and the means by which that role is secured.

3.6 Issues of Reliability and Validity

Qualitative data, by its nature is subjective, involving the participants in subjectively interpreting their experiences within a social context. Quality qualitative data cannot be obtained by removing the subjectivity of participants, rather cross-checking or validation (Wiersma 1991) should be undertaken. Triangulation was undertaken in this research. Miles and Huberman (1994) refer to triangulation as an accepted means of reducing bias by providing multiple instances of evidence from different sources. Yin (1994:78) identifies sources of evidence for case studies as documentation, archival records, interviews, direct observations, participant-observation and physical artifacts. This form of triangulation (using multiple sources of evidence) is also advocated by others (e.g. Patton 1990; Yin 1994). Walsham (1995) who viewed interpretivist research as having an understanding of context at its center suggested quantitative data provides a basis for interpretation explored through qualitative method. Understandings of adoption behaviour which draw on concepts of success and failure place context as central in decision making. Walsham (1993) ‘I take an interpretive study to mean that multiple perceptions are provided by participants, and thus that the interesting data from the study cannot be 'triangulated' to provide a 'true' interpretation, since whose truth should be chosen?. While Walsham (1993) suggests the difficulty of removing bias in qualitative research, triangulation viewed as a means of expanding understandings rather than validating provides a useful research aim. In this thesis the interview transcripts were checked against policy documents, names of key people and dates were checked against documented accounts, and participants were given the opportunity to check and amend their interviews. A number of participants were involved in
recounting the same event in health policy. Validity in all qualitative studies relates to the rigor of the description and the credibility of the explanation (Boje, 2000). It is fair to say that others could, and probably would, provide an alternate interpretation of the data. The duplication of findings of this qualitative study would be difficult.

The researcher sought to impart enough information about the context to contribute to an understanding of it, providing contextual descriptions for each critical event. Details of changes to the social, political and economic context not raised by participants but relevant to the study may have been missed.

3.7 Summary

A critical interpretivist approach guides the collection of three layers of qualitative data focusing on critical events in the history of health policy in Australia. Data is analysed utilizing a genealogical approach to data analysis focusing on the tactics of governmentality in reshaping power relations. The definition and redefinition of the realm of central control as a tactic of governmentality guides the analysis to view the expression of power relations in the policy setting through broad national reform agendas. The chronology of this study concentrates on the calendar of the diffusion of the practice to systemize information through the policy process. The concept of policy as discourse is utilized to examine the transformation of the discursive formation of healthcare through the practice of systemizing information, a practice supporting the creation of expert knowledge. Emphasis is placed on how policy problems are framed and solutions positioned. The intention is to illuminate the motivations of policies, clarifying the role of information systems in policy and practice, and allowing for an explanation of resistance to adoption.

The following chapters of this study of the analysis of the systemization of information within the Australian health setting describe a series of contestations each with its own discursive elements. Chapter 4 establishes the motivations and ideological bases of the major participants and describes the history of ideas diffused into practice following periods of reform which inform the history of the present. In the next two chapters (5 and 6), the tactics of
governmentality are given center stage, and the reactions and responses to policy are presented. In all of these chapters, the intended and renegotiated role of information systems in the policy process is identified. The intended and unintended consequence of policy implementation is exposed, further informing the debate over the nature of resistance.
Chapter 4

The Political Context as a History of the Present 1920 - 1975

This chapter will establish the political context for the policy analysis which will occur in later chapters, establishing the motivations and ideological bases of the positions of influence. It will highlight the existence of conflict in determining policy parameters and the reasons why there were conflicts and how policy parameters were affected. The chapter will aim to demonstrate that reform ideas diffused through systemized information involves renegotiation which brings to the fore the ideas which have been accepted into practice and those postponed.

The manner in which the interests of patient and doctor are formulated is of compelling importance in the politics of healthcare, and is the area of interest in this chapter. The main aim of this chapter is to interrogate how the Commonwealth Government Department of Health sought, in establishing the parameters for policy development, to define its role and to formulate the interests of the profession and the patients to accept this role. The establishment of a Commonwealth Government Department of Health in 1921, the move to establish a pharmaceutical benefits scheme in the 1940’s, and the introduction of a universal health insurance scheme in the 1970’s are investigated because these events demonstrate the redefinition of the realm of central control in the management of healthcare, and the impact of compromise in establishing policy boundaries. By focusing on these reform efforts, a reductive argument of medical professional resistance to State intervention could be avoided and a chance to illustrate the more complex structural factors which impact on the relationship between the State and the profession can be created.

Critical events within the policy implementation process, specifically in relation to the introduction of shared information systems, will highlight points of resistance and change. These critical events will be used to develop an understanding of the effects on policy parameters and as an attempt to interpret strategies used in framing the interests of patients and doctors. The chapter begins by describing the environment in which the health system operated in the early 1920’s to provide a context for the history of ideas which will inform the history of the present.
Australia was federated on January 1st 1901 (Hancock 1997). The Commonwealth Government’s responsibility for matters concerning the whole nation suggested an expanding role. In the 1920’s a Commonwealth Government Department of Health was established (Roe, 1976). This chapter describes the process of legitimizing a role for the Commonwealth Government in determining the direction of a national healthcare system, and later in the chapter explores the Commonwealth Government’s attempt to nationalize healthcare in the 1940’s. The chapter will examine the establishment of a universal health insurance scheme, specifically the political, social and economic influences. Set within periods in which the political debate strove towards public ownership of economic goods, the expanding role of the Commonwealth Government will be examined. This chapter will explore the disputes which occurred during the practice of systemizing information to understand the role of information systems in diffusing reform ideas. The renegotiated systems will produce some understanding of the constraints of the policy environment and Government decision making. With this informed view of the context, the role ascribed to information systems and the possibilities they offer to enact a political exchange can be better understood.

Table 4.1 Summary of contents

<table>
<thead>
<tr>
<th>Period</th>
<th>Reform agenda</th>
<th>Systemization of Information</th>
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This chapter will begin by exploring the environment which existed during the introduction of a National health system in order to gain a greater understanding of the role of systemization of information in political exchanges. The focus is on the transformation of the discursive forms of healthcare. Of primary concern are the strategies used to reframe the problem of healthcare to suggest a role of Government in potential solutions. The chapter concludes by analyzing the set
of rules which determine the discursive space in which healthcare operates following this period of reform. The impact of diffused practices on current policy decision making will be explored.

**Data introduced in this chapter**

Christine MacDonald co-authored the book ‘The Making of Medibank’ with Richard Scotton who is widely regarded as one of the key architect of Medibank (Gardner, Barraclough 2002). Medibank was a comprehensive, universal insurance scheme rather than a nationalized health system introduced by the Whitlam Government in 1975 (after first being defeated by the Senate on 12 December 1973). Medibank involved the Commonwealth Government reimbursing individuals for the medical costs they incurred. It also subsidized public hospitals on condition that they provide free treatment when requested whether as in-patients or out-patients. MacDonald provides rich data in the form of her recollections of the 1970’s reform period. Drawn both from her research and her experience, MacDonald provides insight into the policy implementation process. Interviewed in Melbourne, the interview of ninety minutes covered various aspects of the policy process of the 1970’s, and recent reform efforts.

David Tow, a computer consultant, was engaged by the AMA in 1973 to examine aspects of the computer system being implemented as part of the government’s health insurance program. In 2009 his recollections of his involvement is at times vivid and at other times hazy. With the benefit of hindsight he appears to regret his involvement in the information privacy debate which raged at the time, and the role this debate played in medical politics. However, it is clear from the report which he authored during his engagement with the AMA that he was aware of the AMA’s intent to politicize key findings of his report. His account of events occasionally attempts to apportion blame. Every effort has been made to ignore the more inflammatory comments and only accept those which provide a rich picture of the events as they took place. Tow was interviewed via the phone and face to face in a café in Sydney.

Richard Scotton entered the public service to implement the Medibank program as chairman of the Health Insurance Commission between 1973 and 1976. He had a close working relationship with Hayden (Minister of Social Security) and the Prime Minister Gough Whitlam. In preparing the book ‘The Making of Medibank’, Scotton had access to the personal files of Bill Hayden and
John Deeble (a health economist considered one of the key architects of the universal health insurance scheme). Upon completion of the book, Scotton and MacDonald (co-author of ‘The Making of Medicare’) deposited the collection of unpublished research documents (a mixture of originals and photocopies) relating to the establishment of national health insurance in Australia, as a private collection, with the Victorian Office of Australian Archives. The archived material used here includes primary source material which was in Scotton’s possession but was not cited in the book. These archived documents were retrieved from the National Archives Office in North Melbourne and the relevant material has been used in this chapter.

The analysis of the systemization of information which occurred in the 1920’s and 1940’s draws on data from predominantly documentary sources. Included in the documentary sources used in this chapter are Government policy documents, constitutional case transcripts, departmental records and reports, annual reports of significant institutions, commissioned reports, media releases and meeting minutes, and secondary sources such as newspaper articles and academic literature.

4.1 1920’s - The Context

Throughout the 1920’s in Australia, treatments, legislative responses, preventive approaches, hospital facilities, monitoring techniques of patients, all changed. The role of Government in the provision of health services and the conceptualization of health as more than biological concerns were are the heart of these changes.

Between the beginnings of Federation (1901) and the late 1920’s, a period when the Commonwealth Government was widening its purpose, the administration of health underwent major reform (Gillespie 1991, Willis 1989). Funding for research into public health issues from the international Rockefeller foundation, whose policy was to work only with and through governments, formed the beginnings of a Commonwealth Government Department of Health (Gillespie 1991).

… is in keeping with the established policy of the Board: namely, to co-operate with governments throughout the world in demonstrating the feasibility and economic value of
preventive measures against disease, and thus to aid in creating, in the various countries, popular interest in and support for public health work. (The Rockefeller Foundation Annual Report 1919:72).

The Department of Health was established in 1921 (Roe 1976), Cumpston was appointed Director General (Roe 1976). The science of epidemiology combined with improved statistical method established these disciplines as knowledge industries and the technological developments in medicine, most notably the germ theory of disease (Bastian, 1875), encouraged a population based, scientific view of healthcare (Sawyer, 1923b:329). The scientification of medicine suggested the need for centrally coordinated institutional structures.

Two thirds of those describing themselves as medical practitioners in the 1921 census were in sole practice (cited Pensabene 1980:135). Medicine was practiced in small private businesses (Pensabene 1980:133). It required a significant investment in time and money to participate, beyond nearly all but the wealthiest. The cost of a medical degree at Melbourne University in 1924 was twenty four pounds per annum (cited Gillespie, 1991:6). The basic wage at the time was nine pounds thirty shillings (Heaton, 1921). Few in the population could afford their fee-for-service rates (Handbook for Qualified Medical Practitioners, 1935:956). The economic problem of setting up a practice and repaying university fees affected members of the profession (BMA (Vic) Annual Report 1931). The focus of the British Medical Association (in 1962 the Australian Medical Association was formed) became the economic problem of integrating those outside the market into a position of paying – or having their fees paid (BMA (Vic) Council minutes 1935).

With the exception of quarantine, which was a Commonwealth Government concern, public health was a responsibility of the State Governments during the 1920’s. In most States at that time the Health Minister had additional portfolios – e.g. John Fitzgerald was Minister for Local Government and Public Health in New South Wales (1919), Hal Pateshall Colebatch was Minister for Public Health, Education, Agriculture and North West in Western Australia (1919) (Australian Dictionary of Biography). Between 1895 and 1920, much of the effort surrounding disease control was aimed at detailed individual surveillance centered on the discovery and isolation of ‘carriers’ (Cumpston and Lewis 1989). The practical work of preventive medicine at
the time included sanitation activities (providing safe water, disposing of sewage, and the construction of healthy buildings), infectious disease (recording, monitoring and containing the spread of typhoid, venereal disease, small pox and the plague), and the routine and comprehensive examination of individuals recognized to be at risk from infective or other factors with a focus on pregnant women, young children or industrial employees (Cumpston, 1925:684). The Health Inspectors Association of Australia official report of lectures and proceedings at the Twelfth Annual Conference (1924:16) recorded: ‘In years gone by the local health inspector was regarded as an official of little account. All of this has now changed and the occupation is now coming to be regarded as an honorable profession. Yet within the medical profession the public health worker was seen to be involved in an inferior area of activity’. Cumpston (1925:684) suggested the profession regarded public health as ‘the somewhat uninteresting function of a somewhat lethargic Government department’.

4.1.1 Shaping the discursive structures in healthcare in the 1920’s

4.1.1.1 Expanding the boundaries which define the field of possible objects - Epidemiology

Investigating the medical certificates of invalid pensioners issued since 1910, the Departmental Committee on the Causes of Death and Invalidity in the Commonwealth Government concluded in 1915 that 32% of invalidity was the result of preventable causes (Cumpston and Lewis, 1989). Questioning the efficacy of curative medicine, the problem of healthcare was being defined as a lack of focus on preventative risk management. Following the Spanish flu pandemic, Cumpston (1919) proposed that the Commonwealth Government recognize public health as ‘a department of State activity’ which would embark on research, consulting in public health and education (Cumpston, 1919:127). Justified as part of the nation’s quarantine defenses, Cumpston’s health department focused on bridging the gap between the advanced medical science of epidemiology and its application in practice.

The formal educational structures which applied to medicine during the 1920’s favored a commercial, curative, personalized approach to practice (Willis 1989). In his presidential address to the Public Health Sectors of the 1920 Australasian Medical Congress, Hone (1920) argues strongly for the teaching of preventative medicine to medical students, highlighting its
absence from the curriculum. Hone was a medical practitioner and a founding director of the Australasian Medical Publishing Co. Ltd which published the Medical Journal of Australia from 1914 (Australian Dictionary of Biography). An indication of the growing legitimacy of the preventative approach within the profession is provided by Cumpston (1925):

> after the last war, my medical colleagues returned to Australia filled with a desire to apply to the civil community the great lessons of prevention of disease which had been applied in the army
> (Cumpston, 1925:621, cited Gillespie 1991)

The experience of army doctors who had worked under a centrally coordinated disease focused preventative approach to healthcare is described. Suggesting broad enthusiasm for this approach amongst returning army doctors, the climate for change is highlighted. Implicitly he expresses a view that the best approach to practicing medicine was a preventative approach and not a curative approach.

Epidemiology provided the epistemological underpinning to Cumpston’s view of healthcare. As a specific field of data collection and research, epidemiology was presented as:

> a rigid examination into the causes and conditions which influence the origin, propagation, mitigation and prevention of epidemic diseases in order to throw light into the whole question of epidemics
> (Epidemiological Society of London 1850).

Promoting the enlargement of the territory of medical theory, epidemiology and statistics were suggesting that healthcare concerns the study of all factors contributing to the cause and affect of illness. Information and information systems deployed across populations of people would be required to harness the potential of this new area of expert knowledge. The aim of the Australian Institute of Tropical Medicine, which was answerable to the Commonwealth Government Department of Health became:

> classification and coordination of existing knowledge concerning preventable diseases’, and the ‘preservation of health amongst white or colored inhabitants of the Australian tropics
> (Cumpston, 1925:685)
The science of preventive medicine was to expand the scope of medicine to include factors contributing to the causes of illness, a view of illness as an avoidable condition in modern progressive medicine was expressed. Cumpston (1925) explicitly suggests that creating an area of expert knowledge involved recording, managing, and controlling the dissemination of information. Implicitly it is suggested that the intention to determine diseases for inclusion or exclusion through the classification lists was to be an area of Commonwealth Government control. Ideas about information as collectable and as tied to progress were being diffused through the practices of classification. The Commonwealth Government, in defining the role of the Institute in these terms, was claiming prevention within Commonwealth Government jurisdiction. The direction of research by the Institute of Tropical Medicine changed from physiological to measures of public health and disease control1. This ensured that epistemological validity would be given to medical breakthroughs which the Government considered aligned with its concerns.

4.1.1.2 The new position and role occupied by preventative healthcare

For Cumpston, the involvement of the profession in preventive healthcare required the Government to provide the scientific aids which were too expensive for the doctors themselves through expert advice, access to laboratories and X-ray equipment, information on the latest methods used internationally, and a means to get patients beds in hospitals (Cumpston, 1925:685). In Cumpston’s view the profession would need no greater coercion to adopt preventive medicine2. In this, Cumpston displayed a naïve view of the profession as a unified body, when in reality members of the profession held disparate views on the best way to practice medicine. The Melbourne Permanent Committee for Post-Graduate Work warned that the ‘use of the chemical laboratory as an aid to diagnosis is of very limited use and only in a few

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1 Cilento who was Director of the Australian Institute of Tropical Medicine in Townsville, Queensland, from 1922 to 1924 wrote on this matter in ‘White Settlement in the tropics’, in Pillips, P.D. and Wood, G.L., The peopling of Australia, Melbourne 1928, and more extensively in ‘Nutrition and Numbers: The Livingston Lectures 1936’, Brisbane 1936.

2 Hone wrote over an extended period about the disquiet within the profession, notably in ‘Some neglected factors in the Prevention of Disease’, MJA 4th February 1920, and ‘25 Years of Preventive Medicine in Australia’, MJA 1st July 1939:12-18. The editorial in the MJA from 11th December 1920 ‘A civil medical service’, pgs 535-6 provides an outline of the debate.
conditions are the results of any real value' (MacLean, 1930, cited Gillespie 1991:40). A consistent view of the best way to practice did not exist across the profession.

A number of campaigns which would encourage use of laboratories and knowledge dissemination were undertaken. The Australian Hookworm Campaign (1919 to 1924) was one such example with an aim of mapping ‘the entire continent of Australia and its possessions with regard to hookworm disease, and to carry out intensive operations wherever the disease is found’ Sawyer (1920:291). The disease focused view of healthcare which concerned the study of all factors contributing to the cause of a disease is described. Explicitly Sawyer suggests the importance of information to the control of healthcare. In Europe, Hookworm was noted to be an ‘occupational disease’ affecting mining workers and plantation workers (Sawyer (1920:292). On the basis of the European experience, yet with no precedence in Australia, four States in Australia added *ancylostomiasis* as a compensable disease, under the Workers’ Compensation Acts, if contracted as the result of the occupation of mining (Sawyer, 1923a). Despite no known outbreaks, testing for Hookworm was undertaken with funding from the Rockefeller Foundation (Rockefeller Annual Report 1925). The focus of the disease management effort was productivity, in line with the Federal Governments mandate to manage the economy:

> It is important for the welfare of the industry and the miners that more detailed and complete records (of absence due to illness) should be kept in such mines and be available for studies of industrial diseases. 
> (Sawyer, 1923a: 162)

Describing healthcare as an issue of economic nation building placed healthcare within the jurisdiction of the Commonwealth Government to manage. Explicitly suggesting the need for information in order to manage productivity, engaging employers in the practice of information collection about illness was diffusing notions of healthcare as disease focused and manageable through central coordination.

Notions of Commonwealth Government authority in directing practice decisions were being underpinned by the practices involved in the containment of the Spanish influenza pandemic (Cumpston 1928:320), Venereal Disease notifications (Sax 1984:17, Armstrong 1983:12) and
Hookworm disease (Sawyer, 1923a). These practices involved collecting patient information, sharing patient information, relying on central laboratories to confirm diagnosis, acceptance of state sponsored pharmacological treatments and recommendations. Indicating division within the profession stemming from Commonwealth Government involvement in determining the diagnosis and treatment of disease, Hone (1915) argues that the economic impact of illness to the State placed healthcare within Commonwealth Government jurisdiction:

the cost to the State in lives, in incapacitated individuals, and expenditure on treatment must be set above all (Hone, 1915:507).

Describing the cost of healthcare in respect of work force productivity and its impact on financial disadvantage, Hone suggests the overriding concerns in setting policy direction should be economic welfare.

4.1.1.3 A new mode of functioning of language with respect to healthcare - Health in economic nation building

The forced deportation of Pacific Islanders after 1905 in line with the objectives of the White Australia policy contributed to labour shortages in Tropical Australia (Ranking, Paget and Nielson, 1906). Despite the aim of populating the north with white workers, debate had raged about the fitness of the white race to survive in a tropical environment. The conclusion of the 1920 Australasian Medical Congress in Brisbane indicated that explanations of the potential of the white race to inhabit the north had become an issue of modern medical technique. This was also the view of Clinento who was director of the Institute of Tropical Medicine:

…that the whole question of successful development and settlement of tropical Australia by white races is fundamentally a question of applied public health in the modern sense…white man in tropical countries … is infinitely more largely a question of preventive medicine than a question of climate (Cilento 1926:1)

The public purpose for the Commonwealth Government Department of Health was suggested as nation building, the role of the Commonwealth Government was to include delivery of scientific medicine. Explicitly suggesting the efficacy of modern scientific methods, Cilento (1926) argues
that the problem of populating the tropics with white workers could be resolved with preventive medicine. Healthcare was being conceived of as a concern of the human condition which impacts upon its potential.

What was missing in the 1920’s was a drive from the population for preventive healthcare. Gauging the strength of public feeling at the time is difficult, but disinterest from the community is expressed in correspondence from a Victoria GP in 1922:

... two factors, more than anything else, make successful diphtheria prevention in the country well nigh impossible. One is the incredibly strong prejudice of all classes against the use of any form of ‘inoculation’ whatever for any purpose and the other is the remarkable disregard by Shire Councils of their responsibilities under the Health Act, 1919 (Victoria) (Browne, 1922:62)

Browne (1922) describes the Commonwealth Government’s lack of authority to command obedience. Explicitly suggesting public skepticism towards interventionist scientific medical approaches, Browne determines this as impacting on adoption of preventative approaches. Ideas about preventative health approaches as the best way to practice medicine had not diffused into practice. Implicitly, Browne suggests patient trust as central to adoption of medical practices, implying the dependence of the state on the doctor-patient relationship.

4.1.1.4 A new form of localization and circulation of discourse - disease registers

In Cumpston’s view, the value of the private practitioner to the Government was its position as ‘strategically almost perfect’ for disseminating information (Cumpston, 1919:127) and collecting population relevant information, recording ‘certain prescribed details for patients within specified limits of age and occupation’ (pg125). Cumpston suggests that to make prevention part of medical practice would involve the nationalization of part of the knowledge and time of every practicing doctor (Cumpston, 1919:128).

From 1924 the Commonwealth Government Department of Health began publishing aggregated national data on communicable diseases. Recognizing the clear divide in areas of work practice, the national data on communicable diseases which had been published in the Medical Journal of
Australia 1917 to 1922, was published in the Commonwealth Government Department of Health’s journal ‘Health’ from 1924: changing the way in which the data would be disseminated and presented and establishing Government control.

4.1.1.5 Summary

The idea that a nationalized health system was necessary to nation building and economic development was being formulated. Supporting institutional structures which expanded the theoretical base of medicine to include the scientific methods advocated by epidemiology, the Commonwealth Government sought to establish its role in setting the direction of healthcare. Diffused through epidemiological practices, ideas centering on the connections between the manageability of disease and the need for co-ordination, and scientification and progress, were being informed. Ideas about information as collectible, as tied to the scientification process and as representative of positive facts, and specifically ideas of information sharing in healthcare as necessary, were being diffused through the practice of disease registers and central data collection efforts. The environment for change allowed space for maneuvering. The negotiated position resulted in placing the right to speak on public health issues within Government control, constrained by the need for information supplied by the profession. The process of systemizing information through categorization of disease and establishment of disease registers provided the possibility of redistributing power relations by subjecting the profession to practices which diffused notions of central coordination and a disease focused preventative approach to diagnosis and treatment. The potential to affect a political transfer and afford the Commonwealth Government a new form of circulating discourse was realized.

By the end of the 1920’s, the Commonwealth Government did not have a mandate to set the direction of healthcare: instead the Commonwealth Government had secured a role for itself in the delivery of preventative medicine (Roe, 1976:187). Despite its restricted role, medical research infrastructure under Commonwealth Government control had been established through the Commonwealth Serum Laboratories (established 1916, Sawer 1925) and the Australian Institute of Tropical Medicine: allowing the Commonwealth Government authority to influence the direction of research efforts and create an alternative understanding of illness and healthcare. The Commonwealth Government had supported the expansion of medical technology. Disease
registers, and dissemination of information fell under Commonwealth Government control. The science of preventive medicine expanded the scope of medicine to include factors contributing to the causes of illness, a view of scientific methods in medicine as tied to progress and in the national interest was formed. It was within these boundaries that the Commonwealth Government’s health policy agendas were confined, but made possible.

Attempts to build on these ideas occurred when the political debate strove towards public ownership of economic goods, and an expanded role for the Commonwealth Government. Following the accession of the Curtin Labor Government (in October 1941), the post war reconstruction program took two routes, one was central control of the national economy, the other was provision of a comprehensive system of social services (Galligan 1987, Scotton and MacDonald 1993).

4.2 1940’s – The Context

In a report drawn up by the National Health and Medical Research Council (NHMRC) (formerly the Federal Health Council) and published in The Medical Journal of Australia (1941), details of the principles under which public health would be progressed after the war were described:

This council sees no insuperable difficulty in complete control by the Commonwealth Government, even including the transfer of State Health Departments, and in fact recommends as an ultimate objective such control or transfer with all aspects of preventative and curative medicine including hospitals. On the other hand the Commonwealth Government can profitably subsidize these activities. Any subsidy so granted should be conditioned in such a manner as to promote uniformity of legislation and administrative action throughout all the States. This Council considers that these proposals are not inconsistent with the retention of private medical practice and private hospitals. (NHMRC, 1941:182).

The report suggests that medical services could be subsidized and administered by the Commonwealth Government and delivered through private practices. The report recognizes the possibility of Commonwealth Government run hospitals and medical services, and concedes the need for a national approach to preventative and curative medicine. A role for the Commonwealth Government in setting the direction of healthcare is endorsed. In post war reconstruction planning Chiefley (Prime Minister 1945-1949) noted that the Government
intended to lay the foundation for a comprehensive national welfare scheme to include health services (Commonwealth Government Parliamentary Debates, 1943:548-49).

The editorial in the Medical Journal of Australia shines light on the professions anticipation of change after the war:

Since most members of the profession foresee changes in the future and are agreed that there is room for improvement in the conditions of service given to the public by the profession, a satisfactory State of affairs will be attained only by the diligent application of the best intellects to the problem and the willing cooperation of all concerned.
(Medical Journal of Australia, Editorial, 1941:174)

A climate for change was created by the prospect of returning army doctors, a new government, and a view of the conditions of service (not the practice of medicine) as inadequate. The conditions of service referred to equitable access to medical care. In 1943, cabinet discussed a scheme for providing free health and medical benefits including a salaried medical service with the Commonwealth Government assuming direction, in collaboration with the States (CPD, 1943:548-49). The most significant change during the war and in post war reconstruction planning was the way in which the Commonwealth Government perceived itself as having a role in providing equitable access to core social services. That this would include the nationalization of the medical profession was the area of contention that would be fought on the basis of professional autonomy:

That nationalization of the medical profession would tend to deprive the profession of its freedom and incentive to develop along the natural lines marked out for it by the growth and expansion of scientific knowledge
(Brown, 1941:315).

Indicating the wide acceptance of, and identification with, the science of medicine as defining the medical professionals’ expert knowledge, Brown suggests the professional claim over scientific medicine and its anticipated growing jurisdictional boundaries. The attempts towards a nationalized medicine scheme represented by the Pharmaceutical Benefits Act (1944) would be resisted.
4.2.1 Shaping the discursive structures in healthcare in the 1940’s

4.2.1.1 The displacement of boundaries which define the field of possible objects – Pharmaceuticals

Throughout the 1940’s the enlargement of the territory of medical theory to include pharmaceutical therapeutic treatments as central to the health system were contributing to an understanding of the manageability of health. In the early post-war years there were dramatic developments in almost all branches of curative science-based medicine - anaesthesia, sedatives, stimulants, cardiovascular drugs, hormones, and chemotherapy of parasitic and microbial diseases. The Commonwealth Government Serum Laboratories (CSL) which had produced quantities of vaccines and sera for diseases such as diphtheria, tetanus, typhoid, cholera and whooping cough, was one of only four laboratories in the world licensed to produce insulin (1923) (The Prescription Medicine Industry in Australia, 1973). The therapeutically usable form of Penicillin became commercially available in the 1940’s. The CSL began to manufacture penicillin in 1943 mostly for armed service personnel. Australia provided penicillin to the civilian population in 1944 supplied from the Commonwealth Government Serum Laboratories (Mathews 2008), reinforcing a view of medicine as a social good, health as a manageable service, and supporting an understanding of the appropriateness of central administration in delivering health services. The control of laboratories, the ability to direct research efforts and with expertise in administration, the Commonwealth Government was assuming a role in the developing field of pharmacology. A role in service delivery of healthcare was being assumed through the provision of medicines.

The scientification of medicine and a population disease focus which had been emphasized by epidemiology had altered explanations of the causation of illness.

We can agree with the principle of not making the individual pay for his medicine, since we have largely ceased to regard illness as a form of divine retribution. But any honest doctor would have advised the Minister for Health that only a small number of drugs are curative: that nearly all mixtures which are taken have only a psychological effect: and

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that, while the people want medicine, it is not medicine, in most cases, that they need (Heaslip, 1946:11).

Heaslip describes the difficulty the profession faced in disputing the idea of medicine as a social good and social equity expressed as access to free medicine. Heaslip highlights the acceptance that existed for a Commonwealth Government role in providing equitable access to healthcare. Explicitly suggesting that polarized views existed amongst the profession stemming from the best approach to healthcare, Heaslip expresses his view that encouraging patients to reach for the bottle was an irresponsible approach. The widespread acceptance throughout the population of the efficacy of therapeutic medicines is highlighted. Describing the pivotal role of some within the profession to direct policy, Heaslip suggests the approach was populous. Indicating that the scheme encouraged a reliance on medication and rejection of wider social causes of ill health, authority to speak on the right way to practice medicine was at stake. Heaslip provides an explanation for disquiet amongst professionals advocating preventative for the Commonwealth Government’s approach to nationalized medicine. Implying that the faith placed in therapeutic medicines was ill founded, he highlights the cause of ill health as more complex than pharmaceutical solution suggest. Gillespie (1991) describes this debate as bridging professional opinion which had been divided along the lines of subscribed practice and fee-for-service, galvanizing the BMA (Gillespie 1991:76). Implicitly Heaslip suggests that the debate over the positioning of pharmaceutical therapeutic approaches as central to healthcare was subsumed under the larger debate over the nationalized medicine.

4.2.1.2 The new position and role occupied by the speaking subject in discourse – the generalist administrator

Encel (1955) describes the Australian Public Service prior to the 1940s as comprising degree holders from professional rather than generalist disciplines within influential administrative positions. Of those senior public servants who held degrees in 1936, ‘57 percent had degrees in law, 14 percent in engineering and 7 percent in medicine, making a combined total of 78 percent with professional qualifications’ (Encel 1955:36). Sir Roland Wilson’s appointment to a senior position in the Statistician’s Branch of the Treasury in 1932 represented the first economist to be

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4 Reports in The Age 27th July 1944 in which Hanlon describes ‘Sickness is regarded as too serious a problem to be treated with fee medicine’ suggests the public nature of the debate. Dale, J., 1941 ‘Social Aspects of Medicine’, MJA 9th August 1941 also provides insight into a divided profession.
employed in the Commonwealth Government Public Service (Henry 2007). The public service
did not begin generalist graduate recruitment until 1933, limiting recruitment to 10 per cent of
overall vacancies (Matheson, 2001). With the advent of the Second World War the need for
administration of a wide range of complex tasks in an expanded role for the Commonwealth
Government saw the recruitment of generalist graduates become commonplace (Henry 2007).
Matheson (2001) notes that during World War II control over staff selection shifted to the elite of
generalist administrators favoring those with economics and arts degrees over school leavers and
those with professional degrees. Professional administrators who were not answerable to
external professional bodies rose to senior administrative positions within the public service.
Excluded from senior administrative positions, the professions and the influence of
professionalism were being displaced by corporatism or what Halligan and Power (1992)
referred to as administrationism (Halligan and Power 1992:68).

4.2.1.3 Resisting a new mode of functioning of language with respect to the
administration of medicine

The new era in administrative control was active when provisions in the Pharmaceutical Benefits
Act (1944) suggested the direct control of the prescribing practices of medical practitioners (s22
and s27), in stipulating the circumstances under which doctors could prescribe, and the list from
which they could prescribe. The intention of the Act (1944) was to restrict benefits to medicines
listed in the Commonwealth Government Pharmaceutical Formulary, and only on the
presentation of a prescription written by a registered medical practitioner on an official
Government form, to a Commonwealth Government approved pharmacist (Biggs, 2003,
Parliamentary Library). The expert knowledge of the medical profession was suggested to be
essential to the administration of pharmaceutical therapies. The role of the profession was being
supported as central to the provision of modern scientific medicine. Changing the way in which
the pharmaceutical treatments sought by patients could be obtained required the profession to
submit to centrally coordinated administrative techniques. These changes would act to legitimize
the role of the Commonwealth Government in the provision of health services and create an
opportunity for the Commonwealth Government to direct the practice of medicine.
Phillips (1964), who represented the doctors in their constitutional challenge to the Pharmaceutical Benefits Scheme (1945), described the particular statute as requiring that no doctor should prescribe medication for a patient unless he actually believed, as a result of professional consideration, that the patient was suffering from the disease or disability for which the medication was prescribed (Phillips, 1964). The suggestion was that centrally coordinated administration was necessary to protect the public from over servicing, professionalism as a governance mode was being questioned. When a doctor did prescribe he had to complete the prescription in triplicate. Administrative oversight into the prescribing habits of doctors was being sought. Phillips (1964:257) refers to ‘the requirement of prescriptions in triplicate – that was the last straw’. The act of completing forms prescribed by the Commonwealth Government which would subject the profession to administrative control techniques was rejected. Attempts at top down enforced participation in practice change were being challenged. It was the point of transition from policy into practice that provided the site for contestation.

A constitutional amendment was required to allow the scheme to be reintroduced in 1947. Amendments to the Benefits Act (1947) required doctors, in writing prescriptions for medicines, to utilize forms provided by the Commonwealth Government. They were also required to identify medicines by quoting the reference number in the form (Phillips, 1964). If the patient wanted to pay the full fee for the medicine, the doctor did not need to complete the form. The potential for privatized practices to avoid submitting to centrally coordinated scrutiny of patient treatment data existed, however it required patients to opt out of subsidized medicine. Legislation was enacted to make it compulsory to use the Commonwealth Government supplied forms for all prescriptions which referred to medicines on the Commonwealth Government formulary of drugs (which included all routinely prescribed drugs). The penalty for non compliance was 50 pounds (Galligan, 1987). Enforced participation to gain administrative oversight was being attempted to install corporatism as the dominant governance mode in healthcare.

4.2.1.4 Resistance to a new form of localization and circulation of discourse

Attempts to coerce the profession to submit to administrative control techniques were challenged: it was argued that the requirement to use a form backed by penal sanctions
constituted ‘civil conscription’ (British Medical Association v. The Commonwealth Government (1949) 79 CLR 201). In Justice Williams ruling he stated that if accepted:

> the medical practitioners could be compelled in the course of their practice to perform all sorts of medical duties as, for instance, to give certificates, keep records, and give information...and a law which compelled him to perform them would, in my opinion, authorize a form of civil conscription of his services

(Williams, 1949, 79 CLR 201:8)

Describing the administrative tasks of professional services as within the professions jurisdiction, Justice Williams was suggesting that the Commonwealth Government’s authority with respect of administration did not extend to professional medical practice. Explicitly the requirement to share information and perform administrative duties would constitute central control and would impact upon the professions autonomy. Implicitly, Justice Williams suggests that information sharing was not in the best interests of the medical profession, implying information ownership was necessary for professional autonomy.

Justice Rich emphasized that interference of this kind into the workings of the medical profession warranted serious consideration:

> An extremely important consideration which cannot be disregarded is the confidential relationship of doctor and patient, a relationship akin to that of solicitor and client and priest and penitent. To disregard this relationship compels a doctor to abandon his normal duties and obligations to his patient.

(Rich, 1949, 79 CLR 201:3 at p256)

Describing the intangible aspects of being professional, encompassing ethics and trust relationships, Justice Rich suggests the inappropriateness of scrutinizing professional activities through administrative technique. Emphasizing that confidentiality is at the core of the professional relationship: Rich implies it can best be protected by the private medical consult. Confidentiality of patient treatment information is suggested as necessary to engender the mutual trust required to allow the doctor-patient relationship to develop to the point where patients will reveal the secrets necessary to provide a quality diagnosis and recommend quality treatment. Explicitly suggesting the practice of medicine supported by the constitution was individual personalized healthcare, Justice Rich suggests a view of healthcare as population and disease focused was unconstitutional. Implicitly, Justice Rich was suggesting that submission to
centrally coordinated administrative techniques threatened professionalism as a governance mode.

The High Court decision (1949, 79 CLR 201) supported a view that application of formal legal authority to coerce adherence to Government prescribed practices was a form of civil conscription to which the medical profession were exempt. The Commonwealth Government was restricted to influencing rather than controlling the impact of reform efforts. A view of pharmaceutical therapeutic treatments as central to health established the benefits scheme as a component of Commonwealth Government jurisdiction: however, failure to constitute medical practice as manageable through central control of patient treatment information denied the Commonwealth Government a legitimate role in directing the practice of medicine. The factual basis for the case hinged on the seemingly innocuous requirement to complete a form in triplicate, yet it derailed attempts to gain administrative oversight into the prescribing habits of doctors. The reasoning of the judges was that doctors had an absolute right of free choice in their professional practice that could not be touched, even in incidental ways, by government. The High Court registered a basic preference for private enterprise medicine and complete professional autonomy.

4.2.1.5 Summary

During the period in which a nationalized health system was being proposed, ideas about patient treatment information as of national interest in the manageability of equitable access to medicine were being diffused through centrally controlled standardized prescribing forms. These ideas supported a view of oversight as necessary to ensure equitable access to medicine and to protect the population from over servicing, undermining professionalism as a governance mode while elevating corporatism. The reform ideas which were diffusing into practice through notions of prescribing forms were ideas about therapeutic medicines as effective and requiring medical scientific knowledge to administer. The transition from policy to practice was represented by the process of systemizing information in the form of prescribing forms. The point of transition represented the point at which it became possible to redistribute power relations, the act of completing centrally prepared forms subjecting the profession to administrative techniques. The renegotiated system inadvertently reinforced a view that medical data was related to
confidentiality and should be entrusted to doctors. The role ascribed to the negotiated information systems reflected the accord reached regarding authority to speak: prescribing information under the professions control reflected diagnosis and treatment as linked to scientific knowledge and curative medicine as within professional jurisdiction. Diffusing into practice ideas about therapeutic medicines as effective and requiring medical scientific knowledge to administer, further entrenched the position of private healthcare which became the point of access to prescription medicines. The contest which occurred during the transition of policy to practice created the impression that medical information involves a confidence between doctor and patient, suggesting one of the unintended consequences of policy.

The right to speak on curative medical practice was not afforded the Commonwealth Government. The possibility to steer the direction of medical practice was constrained by the institutional structures which supported professionalism as the dominant governance mode in healthcare. Framing the problem of equitable healthcare as a lack of information on prescribing habits of doctors, the appropriateness of professionalism as a governance mode was being questioned, positioning corporatism as an alternative. This schism influenced motivation towards adoption of information systems. The inability to constitute prescribing as a centrally controlled manageable administrative task through enforced participation illustrated the constraints placed on the Commonwealth Government in setting the direction of healthcare, restricting it to influencing rather than controlling the outcomes of reform efforts. However, the impression that the Commonwealth Government had a legitimate role in providing equitable access to healthcare was provided during the time. The two system approach to healthcare delivery continued and the Commonwealth Government was positioned to assume a role in immunization as part of its preventative approach. The idea that the medical professional is pivotal in health information collection and dissemination was supported during this period.

Attempts to assume a more dominant role in setting the direction in healthcare occurred in the 1970’s when the political debate again strove towards public ownership of economic goods, and an expanded role for the Commonwealth Government. Following the accession of the Whitlam Government (in December 1972) the reform agenda sought provision of a comprehensive system of social services.
4.3 1970's – The Context

The redistributive consequences of Government intervention in Australia had been tolerated (and justified) as a means of ensuring the production of a skilled and healthy workforce, from which private capital could benefit. When Whitlam won the 1972 election he promised to shift ‘resources into the public sector for redistribution in accordance with approved egalitarian ideals’ (Whitlam 1972, cited Sax 1984). The Whitlam Government was constrained by the institutional structures which supported the personalized professional medical services offered through private practices, and was limited to changes in approaches to funding. Yet, the existence of a two systems approach to the delivery of healthcare allowed for emphasis to be placed on community health.

Health is a community affair. Communities must look beyond the person who is sick in bed or who needs medical attention. The Health and Hospital Services Commission (HHSC) will be concerned with more than just hospital services. Its concern and financial support will extend to the development of community based health services and the sponsoring of preventive health programs (Whitlam 1972)

Emphasizing a preventative social epidemiological explanation of health, Whitlam was highlighting his rejection of healthcare as the personalized professional service supported by existing institutionalized structures. As a community affair, the provision of healthcare required a collective response. Whitlam was suggesting a change to the medical domination of health services, and was advocating an active role for the Commonwealth Government in setting the direction of healthcare.

Labor health policies were aimed at expanding the direct role of the public sector in the provision and funding of health services. Whitlam (1972) called for a reconceptualisation of healthcare from a for-profit privatized business to a collective community concern. The interim Committee of the National Hospitals and Health Services Commission report ‘A Community Health Program for Australia’ was added to the list of special purpose health and welfare grants, and tabled in parliament in May 1973. On the 15th February 1973 the Government announced it would provide financial support for family planning. On the 25th February it was announced that
an allowance for carer (the domiciliary nursing care benefit) would be provided. A national school dental service was announced on 9 March 1973. Rapid implementation of policies was a feature of the Whitlam era, catching many off guard and encouraging retaliatory strategies to delay implementation (Scotton and MacDonald, 1993).

Whitlam first offered Medibank as a ‘de facto Labor Party policy in a speech to a professional seminar at the Royal Prince Alfred Hospital, Sydney’ in June 1968 (cited Scotton 2000:42). As mentioned previously in this chapter, Medibank was a comprehensive, universal insurance scheme rather than a nationalized health system introduced by the Whitlam Government after some delay in 1975. Medibank involved the Commonwealth Government reimbursing individuals for the medical costs they incurred. It also subsidized public hospitals on condition that they provide free treatment when requested whether as in-patients or out-patients. Medibank required agreements with States. The Commonwealth Government, through its tax powers, would meet 50 per cent of the operating costs of public hospitals in the States and pay the costs of drugs used in their hospitals (Browning 2000). Doctors performing services at public hospitals were to be salaried, or paid on a sessional or contract basis. Visiting Medical Officers who wished to remain honorary could do so. An essential feature would be the predictability of costs which would require a schedule of fees to which doctors would be expected to adhere. Medibank started on 1 July 1975 following its first defeat in the Senate in December 1973. ‘In nine months, the Health Insurance Commission had increased its staff from 22 to 3500, opened 81 offices, installed 31 minicomputers, 633 terminals and 10 medium-sized computers linked by land-lines to the central computer, and registered and issued health insurance cards to 90% of the Australian population. Its information technology was, for its day, state of the art’ (Scotton 2000:42).

The need to negotiate a settlement with doctors to prevent the derailment of reforms was one of the lessons learnt from the reforms of the 1940’s and is clearly indicated in a memo from Deeble (a health economist considered one of the key architects of the universal health insurance scheme) to Hayden (Federal Minister for Social Security 1972-1975) in September 1973:

Unpalatable as it may be, we cannot force the programme through without reaching some negotiating position with the medical profession. They have, after all, six opportunities
Constrained by the institutional arrangements which supported professional structures, the ability of the Government to enact reform limited it to influencing and not controlling the outcomes of reform.

4.3.1 **Displacement of boundaries which define the field of possible objects**

Credited with assuming a data-driven approach to policy development, Whitlam amassed large volumes of information to allow for critical analysis of the hospital benefits scheme (Scotton and MacDonald, 1993:20).

With Medibank you had Whitlam who I think from 1960, even before Scotton and Deeble had started work on health insurance data, had himself started to ask questions. He could closely scrutinise where the funds were, where the power was and how things worked in health. He already had a commitment philosophically to that. You then had Deeble and Scotton coming together in the middle sixties at the institute of applied economic research starting to look at the concept of universal health insurance. They had a concept of the system in Canada. They had started their work on this. Whitlam was terribly supportive of anything that was going to provide a different perspective. (MacDonald, 2010, co-author ‘The Making of Medibank’)

Describing Whitlam’s desire to provide an alternate explanation for the problems of healthcare, his use of financial data and economic analysis to view health as a technical issue is highlighted. Whitlam’s questioning of the accepted explanation of the problem of healthcare is emphasized, and his desire for information which would provide the Government with oversight is implied. Scotton who had worked in Canada in 1970 on the development of a central database designed to bring together detailed utilization and cost statistics from the provincial medical plans (Scotton and MacDonald, 1993:43) aligned with Whitlam’s approach.

Whitlam asked Deeble and Scotton to put something in writing and that flimsy piece of paper became the health policy. But it was more developed than that would give you to understand. They then went and worked out conceptually how you might put that together. (MacDonald, 2010, co-author ‘The Making of Medibank’)

Highlighting the central role of Scotton and Deeble in architecting Medibank, MacDonald describes the speed with which their ideas about a universal insurance scheme became policy as belying the conceptual clarity of their proposal. The necessity of ‘a computer system for the purposes of operational efficiency and managerial control’ was obvious to both men (Scotton and MacDonald, 1993:43). Although computers were in the early stage of development, their ability to handle large volumes of transactions and store data for subsequent strategic analysis was considered impressive.

Supporting an analysis of data which would provide an alternate view of the state of healthcare was the suggested purpose of the Medibank computer data:

> Information about what is happening in the health care system will be available to the administrators of the programme on a much greater scale and in much more detail than ever before. One aspect of the analysis will be the regular review of doctor’s service and billing patterns’…The computer system is designed to produce information for detailed statistical analysis of every aspect of the plan’s operations. (Health Insurance, Health Insurance Planning Committee (HIPC) Green Paper, April 1973 paragraph 2.83).

Indicating the intention to provide administrators with oversight of professional practice, computer generated data was presented as capable of providing an accurate picture of the status of the health system. Supporting the view of healthcare as a technical issue of managing the affordability of services, the intention to widely deploy statistical measures as an administrative technique is emphasized. Implied is the idea that information was available and when scrutinized would improve the manageability and therefore overall performance of the health system. Also implied in the above excerpt was that an administrators role involved scrutinizing professional practice.

4.3.1.1 Over servicing

Requiring the profession to submit to scrutiny was public skepticism about professional practice and the propensity to over service.

During the 1970’s…’there were lots of sociological studies on medical dominance. Through that whole period there had been that challenge to, and open exposure, that this
was a power structure, that this was not deemed by God how society was to run.
Arbitrary power structures were challengeable.
(MacDonald, 2010, co-author ‘The Making of Medibank’)

Describing the era in which sociologists such as McKewon (1970), Illich (1977), Larson (1977) were taking a sociological approach to medical history and suggesting the medical profession as a flawed professional group serving vested self interest, the notion of the medical professional motivated by altruism was being challenged. In Australia the profession were subject to public scrutiny and accusations of medical over servicing and fee rostering began to circulate in the popular press 5.

That detection of abuses of the health system in terms of over servicing was emphasized in the HIPC green paper detailing the Medibank computer system:

> It is quite unrealistic to deny the necessity … for procedures to detect and control abuse of the insurance scheme
> (Health Insurance, HIPC Green Paper, April 1973 paragraph 2.84).

Positioning the role of the Government as responsible economic manager of a publicly funded system, the intention to apply administrative disciplinary techniques to professional practice was being proposed by the HIPC Green Paper (1973). Suggesting the problem of healthcare as a technical issue of managing the affordability of services, the taken-for-grantedness of corporate control mechanisms in healthcare is stated. Implicitly suggested is that professionalism was no safeguard against over servicing and oversight would be required to protect against abuse of the system.

A disciplinary role for the Government in scrutinizing professional practice and judging it against Government defined right levels of service was considered contentious.

> Essentially I got the impression the Government was interested in looking at over servicing. To introduce the system there had to be some checks and balances. It was an

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5 The Age newspaper, April 16 1971:3, ‘State games’ described the States having agreed to approve substantially higher hospital fees in a bid to force the Commonwealth Government to give more money to the hospital system. The Age newspaper May 18 1971:7 ‘Alian hospital over charging on pharmaceutical services’ described the behaviour of the Alian hospital in Melbourne as overcharging for services claimed via Medibank.
issue, money wasn’t growing on trees at that time. It was going to cost a lot of money. There had to be safeguards. Any safeguard at all was rebuffed. (Tow, recollections of 1973, retold to the researcher 2009)

Detailing the government’s role in responsibly managing Medibank, Tow explains that the focus for control was on over servicing. Implying that professional self governance was an inadequate safeguard against professional self interest, the acceptance of over servicing as a problem area in healthcare and corporate controls as necessary in resolving it is expressed. While Tow suggests resistance from within the profession to corporate control existed, they would be constrained by the ‘common sense’ of controls against over servicing.

4.3.1.2 Over billing

In order to responsibly fund a universal health insurance scheme the Government assumed a disciplinary role in private practice fee setting, introducing a standard rate. In 1972 the AMA established an Economic Advisory Committee with which to negotiate with the Government over fees. Any fee increases would be supported with economic opinion:

Provided our economic homework is faultless, the Government or Treasury being unwilling or unable to increase benefits is no reason for doctors to subsidise health care costs for the community. At that point we have to remind the Government ‘fees are our business and benefits are yours (A.M.A. Gazette, July 13, 1972:4)

Recognizing the need to provide the epistemological demonstration valued by the government, the suggestion that a shift in power relations had taken place is made. Highlighting the way in which professional decision making about fees was subject to economic scrutiny outside the professional boundaries, the AMA was seeking to reclaim fee setting within professional boundaries by controlling the application of economic analysis. The legitimacy accorded economic health administrative techniques is indicated, suggesting the view of healthcare as a technical issue of managing affordability was understood to be the issue. The response implies there was still room to maneuver in negotiations. Implying a rejection of the view of healthcare as a community concern, autonomy in the running of their professional private practices was suggested as the focus of disputes.
The issue of over-billing was extensively covered in the green paper proposing the new Medibank computer system. Specific proposals were outlined:

The Committee has given consideration to further steps which might be taken in respect to doctors who persistently charge fees above the schedule. There are three basic lines of action:

i) publication of the names of doctors who regularly over-bill,

ii) establishment of competitive public clinics in areas where over-billing is general, and

iii) declaration of doctors as ‘non-participating’ for the purposes of the scheme and ruling their fees ineligible for benefits, or eligible for benefits at a lower rate.

(Health Insurance, HIPC Green Paper, April 1973 paragraph 2.58).

The lines of action which would be taken to discipline non compliance amongst the profession are described, the intention to undermine the institutional structures supporting professional status is detailed: the doctor patient trust relationship, the monopoly of practice, and financial reward. Explicitly stated is the dependence of the profession on the Government for ongoing support of its practice autonomy. Implied is the suggestion that healthcare understood as a technical problem of administrative oversight of over billing and over servicing could be conceived as manageable.

In 1973 the AMA commissioned Tow to highlight apparent deficiencies (Tow 1973) in the computer system described in the Health Insurance Planning Committee report.

The core thing was Government would find out what they were doing, how much they were billing, how much they were charging. There was a charge above the standard rate. That would mean they would have to open their books to the tax department and they hated doing that. When they use Medibank everything would be visible. This was a substantial issue. They wanted to keep control and cover up a certain level of taxable income. It was about privacy.

(Tow, recollections of 1973, retold to the researcher 2009)

Describing a section of the medical profession who held a view of healthcare as a for-profit business as being guided by self-interest, Tow indicates the profession wanted to protect itself from scrutiny. Detailing the transparency into billing processes that the computer system would offer, Tow highlights the introduction of Government oversight of the fee setting practices of
private businesses as an issue. Explicitly, Tow suggests information transparency would provide the Government with a disciplinary tool to change practice behaviour. Implicitly, he suggests information transparency would not support professional autonomy.

4.3.1.3 Summary - Expanding the boundaries of administration

In summary, the boundaries of management technique were extended to healthcare through economic measures which acted to redefine the problem of healthcare as a technical issue of managing over servicing and over billing. The problem of healthcare conceived as a technical problem of managing affordable healthcare enabled healthcare to be conceived as manageable through central administrative control. Expertise in data analysis and economic measures favored by corporatist control methods were impacting on the professional boundaries which secured professional autonomy. The Medibank computer system, which would subject the profession to centrally controlled administrative techniques and allow scrutiny outside professional borders, was a site of contestation.

4.3.2 A new mode of functioning of language with respect to objects – health as a community concern

Healthcare framed as a problem concerning community access to affordable services and requiring coordinated central management legitimized Medibank. As MacDonald in interview with researcher explains:

... Medibank was actually narrower and more conservative in focus but it was conceptually clear at the start. When you had the battles, you had the battles about a conceptually clear program. Part of what was happening was an erosion of the States powers. Whitlam was hell bent on eroding their powers because he thought you needed uniform systems across Australia and uniform policy direction......the dominant discourse was about access and equity, and therefore the strategy that Whitlam adopted for Community health and the financial arrangements through Medibank both at GP’s and public hospitals were the way to achieve that. That was what became the dominant discourse in the 1970’s access and equity and not prevention.
(MacDonald, 2010, co-author ‘The Making of Medibank’)

As a national problem of access and equity, a centrally coordinated solution would be required. Highlighting that the battles over jurisdiction were not restricted to the profession but also
involved the State governments, MacDonald indicates that this was an inevitable consequence of the introduction of a Commonwealth Government administered universal health insurance system. Considered conservative because it did not question the dominance of acute care, MacDonald suggests the narrow focus helped identify issues. Conceptually, Medibank involved the major stakeholders ceding power to the Commonwealth Government. Implicitly MacDonald suggests that the Medibank computer system was one of the uniform systems which would contribute to eroding State Government power.

Scanlan, the Victorian health minister from the conservative Liberal party at the time, indicated in a memo to Hayden the direction the political dispute would take:

I am nonetheless concerned that the confidence of the public of Victoria will be affected adversely by the knowledge that intimate medical details are likely to be recorded at a central bureau, possibly for an indefinite period
(NAA (a):MP4025, 19, letter to Hayden from Scanlan, 17th August, 1973)

Public skepticism towards Federal Government control of personal information was highlighted as an issue: Scanlan implies public fear would be exploited in the political debate. Explicitly suggesting the storage of ‘intimate’ medical details, Scanlan highlighted a view that explanations of illness involved information of a private nature. Implicitly suggested is that the Commonwealth Government would not be considered trust worthy in dealing with information privacy, and that medical information is an individual matter.

A view of healthcare as involving relationships of trust was used to underwrite a role for the Victorian state government:

You will be aware of the extreme difficulty in convincing members of the public that their records would be used only for impersonal statistical purposes…..I am writing, therefore, to advise you at this early stage of your planning that I regard it as my duty to the Victorian public to seek the concurrence of the Cabinet immediately for the introduction of legislation in the Spring Session of Parliament aimed at preserving the confidentiality of patient records in the hospital system of this State……. the purchase of the computer system should not proceed until its role is clearly established
(NAA (a):MP4025, 19, letter to Hayden from Scanlan, 17th August, 1973)
Describing his intention to adopt institutional arrangements which would support the status quo and a view of healthcare as a personalized service, Scanlan was suggesting data privacy would be the tool used to resist ceding power to the Commonwealth Government. Outlining a role of the State Government in protecting patient privacy from federal interference, the State Government was pitting itself against the Commonwealth Government in the eyes of the public. Explicitly suggesting a role for State governments in maintaining data privacy, the implementation of a central computer system, the point at which policy would be translated into practice, was being resisted.

Victoria’s opposition to the Health Insurance Program was demonstrated through its attempt to introduce legislation to protect information pertaining to individual medical records from hospitals – information not actually required as part of the Health Insurance Program:

Mr. Scanlan has presented his Bill as being one to protect privacy of medical information and to control the flow of Australian Government financial assistance to individual hospitals. It has been obvious that one of the purposes of the legislation is to attempt to obstruct the Australian Government Health Insurance Programs, that, of course, is Mr. Scanlan’s political prerogative.

(NAA (f):MP4025, 8, Press Statement by Hayden, 8th November, 1973)

Dismissing suggestions that privacy was the real area of concern, Hayden highlighted that the Victorian Government had not previously found it necessary to legislate to protect the confidentiality of Victorian patient records held with the ninety health insurance funds operating throughout Australia, some of whom also used computers (Hayden, 30th August, 1973). Explicitly, Hayden describes ceding power to the Commonwealth Government as the battle. Implicitly, Hayden suggests his understanding that information ownership had become the site of contestation.

4.3.2.1 Privacy and Information Ownership

The ‘Tow Report’ authored by David Tow was an eleven page report provided to the AMA detailing a technical opinion on which to argue the privacy debate. Using the principles outlined in the Younger Committee report (UK) relating to the handling of personal information by computers, the report found Deeble’s (1973) proposed system lacking. The suggestion that
billing patterns would be analysed and that a management information system would be implemented implied the use of data for a purpose other than claims benefit, or at least for a purpose that was not clearly stated. The report went on to suggest that there were no protections in place to prevent the hoarding of data for future use, and that the system design was inflexible, relied too heavily on the existing communications network, and was too complex to be introduced by the timeline defined (July 1974).

Indicating that patient data containing information on professional decision making was to be shared centrally, it was suggested that the sensitivity of the data would require special procedures to ensure its protection:

It is well known that medical information such as clinical observations are generally difficult to code in a form suitable for electronic processing. Clinical observations are usually used as evidence in support of a decision ranging in importance from marginally insignificant to crucial. Has allowance been made for doctors to review patient histories and make amendments in the light of new information? Because of the extreme sensitivity of medical data, the author believes that security is a vital consideration that should be neither deferred nor treated superficially (NAA (b):M4025, 1, Tow Report, August 29 1973:6/7).

Rejecting a view of professional decision making as subject to management, Tow was suggesting that patient records were intimately involved in the processes by which the profession creates its expert knowledge. Tow describes the inappropriateness of applying corporate control through administrative techniques on professional decision making, describing clinical observations as within the realm of professionalism. Drawing attention to the lack of clinical practice knowledge displayed in the system processes, the administrative focus of the computer system is highlighted. Implicitly the response suggests the Government as lacking authority to speak about clinical practice.

The issues of security and privacy and Government control of computer data banks were emphasized in the Tow Report (1973) to assist the AMA in strategizing to maintain the status quo:

The public feared that if information about psychiatric ill health got out to employers, the information might get around. In those days doctors had a lot more power over patients and the risks could be amplified about the technology more easily. People just didn’t
know, and if the doctors said to them ‘the government/big brother would have access to their medical records’ they immediately assumed that somehow the worst could happen. (Tow, recollections of 1973, retold to the researcher 2009)

Pointing out the stigma and judgment which particular illnesses carried, and the professions ability to determine the cause of illness, Tow was suggesting the enforced participation of patients in maintaining information privacy. Explicitly suggested was that patient fear of stigmatization was utilized to create privacy concerns with respect of centralized databases. Implicit in the response is the suggestion that patient information ownership was being exploited to underpin the trusted doctor patient relationship.

The AMA’s official reply to the HIPC Green Paper in relation to the proposed computer system used the Tow Report findings to suggest:

Inter-relationships between the patient and his doctor, and the privacy between the patient and the hospital system, as well as the possibility of information derived from profiles of the individual doctor’s professional practices being made public, posed threats to the civil liberties of patients and of doctors (NAA (c):M4025, 1, AMA reply to the commissions report, p19, paragraph 152, August 1973).

Rejecting the idea that healthcare was a community concern, the AMA was suggesting individualized trusted relationships in medicine protected civil liberties. Information privacy in healthcare was equated to freedom. Explicitly stated in the reply was that the current arrangement under which doctors and hospitals owned patient information ensured freedom from interference. The Medibank computer system was being undermined by three core messages: 1) the destruction of the doctor-patient relationship; 2) an authoritarian State imposing judgment; and 3) an inability of governments to maintain the privacy of individual medical histories. Implicitly suggested was the Government would use information about patients and doctors to exercise control. The AMA demonstrated its intention to shift the nature of the debate from one of access and equity and Commonwealth Government control to an ideological debate about whether healthcare was a personal or community concern.
Indicating the seriousness with which the Government considered the potential of the AMA’s interpretation of the privacy issue to resonate, Tow was requested to present his report to Hayden and Scotton in August 1973:

> It was a very tense meeting. I talked to my report in that meeting. There were privacy issues. The information would be centralized. It related also to communication. Information would be sent off. One form to Medibank and one form elsewhere, doctors would have one. In those days a big centralized system was considered pretty open. The technology was new. You could use scare tactics pretty easily, and bureaucrats couldn’t defend very easily.

(Tow, *recollections of 1973*, retold to the researcher 2009)

Describing the strength of the AMA’s negotiating position as its ability to resonate with the public, Tow suggests the terrain on which the renegotiation of the system took place. Explicitly stated was that the inexperience of the Government in computing was exploited. Implicit is that information was considered important to the management of healthcare and that patient information privacy was a factor that could derail plans for central control over the direction of healthcare. Privacy of computer information about individuals had received international recognition as an issue for governments. The Swedish Data Act of 1973 required the registration and approval of every nongovernmental computer based file of information on individuals, and most governmental files (Stigler, 1980:633).

To avoid derailment, a press Statement issued on 2nd September guaranteed legal protection against any invasion of privacy under the health insurance program. While noting that:

> at the moment, patients’ medical records kept in over 90 private health insurance funds in computer or manual systems are not protected by law in any way…….It is also well known in legal circles that some doctors make complete individual medical histories available for use about patients for the benefit of private insurance companies where compensation cases are involved…….The absence of any legal redress or control by individuals in the field of personal medical privacy in general is totally unsatisfactory.

(NAA (e):MP4025, 8, Press Statement by Hayden, 2 September, 1973)

Describing his frustration that privacy was going to dominate the public debate on universal health insurance, and Government involvement in healthcare, Hayden suggested the current arrangements under which doctors owned patient histories was no guarantee of freedom from interference. Explicitly supporting the idea that a medical history was an individualized personal
record, Hayden was suggesting its value to private insurers was in avoiding payment. Hayden recognized the privacy issue was not purely a political issue but was of concern to patients. Implicit is the suggestion that the profession was exploiting the doctor patient relationship and privacy, motivated by self interest.

4.3.2.2 Summary - Healthcare as a community concern

Despite framing the problem of healthcare as a technical issue of managing the right level of affordable services, the right to manage the system was not accorded the Commonwealth Government. The privacy debate had emphasized that neither the States nor the profession accepted the notion of health as a community concern which would require central coordination. Privacy was used to diffuse the notion that healthcare was concerned with personal individual interactions, undermining conceptualizations of health as a community concern. The failure to diffuse the idea that health was a community concern led to a renegotiated system which transferred to the medical profession responsibility for disciplinary powers over false or excessive Medibank claims (Hayden 1974), allowing the profession to avoid scrutiny from groups outside the professional boundaries. The right level and quality of service remained to be determined by the profession. The compromises reached meant that while the Government gained agreement that data could be collected and stored, the universal system had no mechanism for setting limits on the total volume of claims. Inappropriate practice became defined as practice unacceptable to the professional body (Breen, Plueckhahn, Cordner, 1997). The unintended consequence of policy was to diffuse a notion of the problem of healthcare as technically manageable, suggesting an area of Government responsibility, while failing to legitimize a role for the corporatist control mechanisms in managing healthcare.

4.3.3 The new position and role occupied by the speaking subject in discourse – healthcare as manageable

In a letter from Hayden to Whitlam in May 1975, the compromise over administrative oversight and interdependency between the profession and the Government is stressed:

    The only problem I fear is that some doctors may adopt guerilla tactics against Medibank and refuse to provide basic data on bills or accounts, e.g. item number or description of medical services, without which a claim cannot be processed. ... My own feeling now is
that in the initial months, so that we can establish credibility and a reputation for efficiency, the Commission should not be too precise and rigid in its requirements in relation to the details supplied by medical practitioners in claims. 
(NAA (g):MP4025, 38, Letter from Hayden to Whitlam, 24th May 1975)

Describing his understanding that governments’ power lies not in its strength to coerce, but in negotiating in such a way that its credibility and subsequent power increases, Hayden was advocating accepting a situation in which the profession would not be subjected to administrative control. Illustrated in this informal e-mail is the recognized importance of information to the concept of healthcare as a technical issue of regulating the right level of affordable services. The memo details the choice taken to opt for the pragmatic approach of securing a win at the larger debate level of Federal Government involvement in providing universal health insurance, delaying the administrative arrangements which would have subjected fee-for-service private businesses accessing public funds to scrutiny. The difficulty in dismantling universal health insurance might suggest the astuteness of this compromise, although it left an administrative burden that could not be ironed out in the ‘initial months’ as Hayden had hoped, but continued to plague governments for years to come.

Medibank provided the Federal Government with the right to speak about the cost of healthcare and the appropriate level of funding for a universal system of healthcare. Budgetary controls, rather than administrative controls became the tool which could be used to bring about practice change.

4.3.3.1 Computer generated reports

The processing and payment of claims, registration of beneficiaries, maintenance of records relating to doctors and hospitals, maintenance of medical benefit fee schedules, production of management and research statistics and the application of accounting and financial controls (HIPC report, 1973 section 7.27), were centrally coordinated and reported via the Medibank computer system. The ability to present a picture of the financial management of healthcare was provided by the information processed in the Medibank computer system. The administrative oversight sought through the introduction of the Medibank computer system took some time to eventuate. It was not until the 1990’s that the Health Insurance Commission through the
Division of Fraud and Over Servicing could conduct data analysis to compare the service profile of each practitioner against an average profile of his or her peers according to information obtained through billing practices (Viveros, Nearhos and Rothman, 1996).

The Medibank saga enabled all governments in Australia to understand that they never ever had again to be held hostage to the AMA. They understood how to play that power game. It was almost impossible prior to Medibank to go against what the AMA asserted. They really held governments’ hostage to their desires. That’s why there were all of those battles about medical benefits.
(MacDonald, 2010, co-author ‘The Making of Medibank’)

MacDonald in interview with the researcher suggests that Medibank provided the Government with the means for talking about healthcare, allowing for an alternate perspective to be offered.

The profession maintained ownership of medical records and the processes which would apply scrutiny to professional practice.

4.3.4 Summary - Shaping the discursive structures in healthcare in the 1970’s

During the transition to a universal health insurance scheme, ideas about health information as important to the national interest of managing equitable access to affordable healthcare were being formed. These ideas supported the process of legitimizing healthcare as a community concern. Diffused into practice through the Medibank billing system was the idea that the manageability of equitable access to healthcare is a technical problem of regulating the right level of affordable services, rather than political problem of social equity. Concepts of health information as inseparable to the manageability of health were formed. The enduring legacy of the ideas diffused into practice during this period was the impression it created that health could be managed though tighter administrative oversight, implying a ‘right’ mix of services which could be controlled when information is made available for analysis.

The reform ideas which did not diffuse into practice became evident by examining the renegotiated information system. The renegotiation of the Medibank computer from a role in monitoring practice behaviour to providing only billing information failed to constitute medical practice as manageable through centrally controlled information about practice. The unintended
consequence of policy was to diffuse a notion of the problem of healthcare as technically manageable, an area of Government responsibility, while failing to legitimize a role for the corporatist control mechanisms in managing healthcare. Entrenchment of the idea that the profession provides privacy protection of medical information and ideas about medical information as intimate provided further support for a view of healthcare as an individual service, and undermined attempts to diffuse ideas about health and illness as a community concern. Ideas about health as a community concern were further undermined by the professions ability to resonate with patients’ fear of being stigmatized.

The idea that a national health system was necessary to ensure equitable access to quality healthcare, ideas which were formulated in the 1920’s and 1940’s, became accepted in the 1970s allowing for an expanded role for the Commonwealth Government in setting the direction of healthcare. The role ascribed to the negotiated information systems reflected the accord reached regarding authority to speak: billing information to fund healthcare fell under Commonwealth Government control and reflected the problem of healthcare as affordability, placing financing healthcare within Commonwealth Government jurisdiction: practice information fell under the professions control reflecting health as a professional personal service within professional jurisdiction.

To this point in the analysis we have focused on the set of conditions which were present at particular moments in time to make possible a discursive transformation. An analysis of the transformations of the discursive formation of healthcare – the mutation of the discursive space or the change environment for action – involved identifying changed jurisdictional or epidemiological boundaries, new positions and roles occupied by speaking subjects, new manner of talking about healthcare, new methods for formulating or disseminating discourse. In the next section, the rules which came into affect so that all of the concepts, operations and theoretical options of the health discourse are influenced, creating the taken-for-grantedness or health problems and solutions offered, is the focus.
4.4 **The Content of Change - The Lasting Impact of Reform Attempts**

4.4.1 Changing the practice of medicine

Expanding the role of Government in health from an interest in the health of the population to setting the norms of the population and the body was at stake in defining the problem area of preventative health, and establishing information gathering procedures during the 1920’s. The idea that a nationalized health system was necessary in the constitution of citizenship, and to national stability and economic development, was being formulated throughout the 1940’s. Such a definition of health would legitimize a role for the Commonwealth Government in setting the direction of healthcare. Diffused through epidemiological and prescribing practices, ideas centering on the connection between scientification and progress, the manageability and curability of disease and the need for oversight were being embedded. Ideas about information as collectible, as tied to the scientification process and as representative of positive facts, and specifically ideas of information sharing in healthcare as necessary for good management, were being diffused through the practice of recording diseases and recording prescribing behavior.

The disruption to power relations that took place led to a negotiated position, resulting in placing the right to speak on public health issues within Government control, constrained by the need for information supplied by the profession. The process of systemizing information provided the possibility of redistributing power relations, which in the 1920’s was successful at affecting a political transfer and afforded the Commonwealth Government a new form of circulating discourse, and in the 1940’s reinforced a view that medical data was related to confidentiality and should be entrusted to doctors.

The partnership Cumpston had envisaged in which the State and preventive medicine would, by managing the basic causes of many illnesses, subordinate curative work, never eventuated. The partnership required an accord with the profession in which it accepted its role as servant to the State. Such an accord was not reached, creating the position where information sharing could become a negotiating tool, whose bargaining position gained in strength with the judiciary decision reached in relation to the prescribing forms. The professions value to the Government with respect to information gathering and information dissemination was confirmed.
Despite the referendum and constitutional changes which provide for Federal Government power over aspects of healthcare, without the necessary convergence of judicial thinking and party political will, reform was unsuccessful. The mutually beneficial relationship forged between the States and the profession in repelling federal attempts to expand control – the requests to share data as the focus for resistance – demonstrate the fragility of the federalist arrangements in Australia in effecting reform, and the potential for exploitation. The turning point in Australian health policy direction: namely the defeat of this wider vision of public health and its replacement by policies which are constrained to providing access to the existing pattern of private health services, with only approaches to funding as the differentiator, were the most glaring lasting impact of the battles of the 1920’s and 1940’s. The battle for service data in the 1970’s confirmed the doctor patient relationship as a key institutional structure supporting professionalism. Conceptions of healthcare as centrally manageable are constrained by privacy linked to a concept of confidentiality in professional relationships. Assuming a pivotal role in funding healthcare, the Commonwealth Government was able to apply pressure to professional boundaries and expanded the boundaries of corporatism in healthcare. The request for data from doctors, in the form of consistent reporting of disease in the 1920’s, prescribing information in the 1940’s, and service and billing information in the 1970’s were required to enable the enactment of reform agendas, and so became sites of contestation.

4.4.2 Changing ideas about healthcare

The idea that a nationalized health system was necessary to ensure equitable access to quality healthcare was being formulated, allowing for an expanded role for the Commonwealth Government in setting the direction of healthcare. The diffusion of these ideas via practice had mixed results, yet the taken-for-granted ideas which form the history of the present following the reforms of the 1920’s, 1940’s and 1970’s involve concepts of health information as of national interest in the central management of risk and in the manageability of health. The impression that medical information involves a confidence between doctor and patient was also been fostered, suggesting one of the unintended consequences of policy. The role ascribed to the negotiated information systems reflected the accord reached regarding authority to speak: disease registers under Commonwealth Government control reflected health as a community issue and
public health as within Commonwealth Government jurisdiction: prescribing information under the professions control reflected health as treatable and curative medicine within professional jurisdiction: billing information under Commonwealth Government control reflected equitable healthcare as a technical matter of managing affordable access to healthcare, and medical patient data under professional jurisdiction confirmed healthcare as an individual personalized service. The idea that the medical professional is pivotal in health information collection and dissemination has become self-evident.

The redefinition of the realm of central control to include healthcare involved concepts of healthcare as contributory to economic development and national security. Citizenship was constituted to include the right to healthcare, a right which could only be provided by a centrally managed system legitimizing a role for the Government in setting the direction of healthcare. Categorization of disease using epidemiological statistic methods established an idea of disease as a community/population wide problem. It also supported views of healthcare as scientific, and information as necessary for good management of healthcare. Legitimate perspectives of the appropriate model of healthcare were delimited by the ability to produce scientific findings, using expensive technology which required doctors to submit to institutional rules – whether a private hospital or Commonwealth Government run serum laboratory. A concept of equitable healthcare as a technical problem of managing the right level of affordable services was underpinned by the central collection of service and billing information. Attempts to constitute medical practice as manageable through central control were resisted and the unintended consequence of policy was entrenchment of the idea that two systems of healthcare delivery are necessary, community health and individual healthcare. The translation of policies into practice is not straight forward, even in periods when coercive methods were considered to form the modus operandi.

4.4.3 Rules establishing the limits and forms of appropriation of discourse

The lasting impact of Cumpston’s (1920/1940) attempts to formulate the interests of the profession and the patient was the establishment of a legitimate area of State intervention in the provision of health services. Cumpston succeeded in placing boundaries on the problem area to
be called preventative healthcare by exploiting epidemiology and statistics as an unclaimed area of expert knowledge. Commonwealth Government intervention to affect the pattern, type, nature and access to medical services was in part achieved by creating knowledge in epidemiology and pharmaceutical manufacture through directing research efforts. The establishment of the National Health and Medical Research Council (NHMRC) in 1936 under the control of the Commonwealth Government provided for the ongoing production of public health knowledge. The NHMRC represented a move towards larger teams of scientists dependent on public funding, subject to the councils processes of decision making.

The fields of relevance and definitions of legitimate perspectives were delimited by control over the research efforts, ensuring all new knowledge in the area of medical research focused on public health concerns – further legitimizing a role for the Commonwealth Government in healthcare. Yet the Commonwealth Government did not have it all its own way, the board of the NHMRC included State Medical Officers who represented their own interests, and ‘three representatives of the medical profession nominated by the Federal Committee of the British Medical Association in Australia’ (Hurley and Murray, 1968:206). Authority over an aspect of healthcare provisioning was never going to be just given to the Commonwealth Government. Authority must, as Foucault (1996) suggests, be problematised, negotiated and constituted.

Expert knowledge viewed as a social process provides the opportunity for transferring power by transferring the value placed in one area of expert knowledge to another. The Commonwealth Government attempted such a transfer in both the 1920’s and the 1940’s. Attempts to elevate preventive medicine and statistical epidemiology, and the ‘expert knowledge’ invested in therapeutic medicines combined to change the value of the role of diagnosis and treatment in health, potentially impacting on the medical professional’s legitimate claim to the ‘authority to speak’. A role for the Commonwealth Government in managing the health of the workforce was forged, concentrating the research efforts on occupational diseases. A new discursive space was opened up by developments in epidemiology and statistics which created space for claims to expert knowledge in the form of disease registers and containment/treatment strategies. During the 1970’s expert knowledge of economic techniques and corporatist control mechanisms was seconded to grant the Commonwealth Government authority to speak about the administration of
healthcare. Yet, the continued reliance on the expert knowledge of health professionals provided them with authority to speak. This is the area of struggle. Information as the site of contestation is not surprising, as information was pivotal in effecting the transfer between one area of expert knowledge to another.

Setting the context for reform involved creating a problem area – in the 1920’s the occupational disease of Hookworm required disease registers as part of the proposed solution – in the 1970’s access to affordable services required management of billing and service information as part of the solution. Highlighting deficiencies in doctors record keeping of disease information, and resistance to any oversight of prescribing habits and servicing and billing habits, has suggested the inadequacy of professionalism as a governance mode in a system which allows private providers access to public funds. Construction of demand for services by ignoring prevention and over billing has framed the debate between a professional mode of medical service provisioning and a corporatist mode.

Strategies used by the Commonwealth Government in the 1920’s, 1940’s and 1970’s created the impression that health could be managed though tighter administrative oversight, implying a ‘right’ mix of services which could be controlled when information is made available for analysis. Social epidemiology opened a new discursive in which the constitution of equitable access to affordable healthcare was negotiated. Healthcare was conceptualized as a technical resource allocation problem, with the Commonwealth Government’s role legitimized as protecting the public from over servicing. The Commonwealth Government expanded its sphere of influence from the right to speak on public health issues gained in the 1920’s and 1940’s, to the right to speak about the costs of healthcare following reforms in the 1970’s, while being denied the right to determine demand and supply levers. The central positioning of systemized information in the transfer of power from the states and the profession to the Commonwealth Government has facilitated privacy as a strategy in resisting Commonwealth Government authority.
4.4.4 The rules limiting and forming the sayable in discourse – framing the problem of health

In advancing the idea of preventive medicine Cumpston had promoted a view of the science of public health as a significant source of power for the State, viewing social and legislative reform in health as a means to improving productivity and the race. The rapid growth in knowledge about disease and health in the form of epidemiology and understanding of various hygiene factors such as diet, sanitation and housing, created the expectation that medical science could control the spread of disease through detection and treatment. With it came the expectation that disease could be managed. In this context the problem of healthcare becomes detecting, treating and monitoring disease, and the solutions proposed aim to manage the ‘at risk’ individuals or groups. The practice of medicine focuses on facilitating health, not ‘providing’ health as a cure. Disease, as a collective problem impacting on economic productivity or national security, requires the State to protect the populous by selecting the diseases which pose the greatest risk and direct resources towards managing the disease and the allocation of medical technologies. Individuals withholding consent to treatment or detection pose a risk to the collective, the rights and responsibilities of the individual are called into question.

The collective nature of healthcare was emphasized again in the 1970’s when Whitlam stated that “Health is a community affair” (Whitlam, 1972) emphasizing the view that health relationships involve social networks with democratic overtones. Elevating the influence of social factors in healthcare services, while suggesting that curative medicine was exploitative, supported a view that reform in health was a means of reshaping society along egalitarian lines. By advancing the social sciences in public health, the science of economics proved to be a significant source of power for the State, undermining the social power of medical science and medical scientific knowledge. In this context the problem of healthcare became coordinating the allocation of resources and providing access to health services. The solution was to protect the population from over servicing and over billing. Despite the Community Health Programs focus on preventive medicine, the resurrection of preventive initiatives took a back seat to concerns for equitable access to curative services through a universal insurance scheme. The definition of preventive medicine claimed by Cumpston in the 1940’s was surrendered for a less well defined one during the negotiations with the profession and the State - the central interests of the
Commonwealth Government were re-defined away from service delivery to provision of services via an insurance scheme as the area of structural reform. Attempts to redefine the relationship between the doctor and the patient existed by influencing perceptions about the efficacy of healthcare delivery services. By presenting the problem of healthcare as a technical problem of resource allocation and administrative oversight, the Commonwealth Government was able to secure for itself funding responsibility for healthcare and with it authority to speak on the direction of healthcare. The unintended consequence of this was that the focus on access to curative services underwrote ‘sickness’ care and perpetuated the predominance of the fee-for-service system, adding complexity by giving private practitioners access to State funding.

4.4.5 The rules limiting and forming conservation of discourse – personalized medicine

The idea that disease can be managed shakes the foundations supporting aspects of medical knowledge. The basis for private medical practice is anchored to providing personalized medical services, treating the individual through the establishment of a one to one relationship. Curative medicine as an approach to healthcare is built on the one-to-one relationship between a doctor and the patient. It involves advise, diagnosis and treatment – the quality of these services are provided for by the expert knowledge of the professional. The curative approach places a direct responsibility on the patient to seek attention when a health problem occurs and to pay a fee. This view was reiterated by the Federal council of the BMA in 1943 in which it resolved that:

It was recognized that whilst the health of the community is a national matter, there is a duty on every individual to accept moral and social responsibility for his health and that of his dependents: also that this individual responsibility should form one of the basic principles of any medical service (cited Scott-Young, 1962).

This ethic of individual responsibility for health is enforced through the patient having to seek out the doctor at the doctor’s residence, or specialists at a hospital – making an individual decision to submit to the medical examination and demand services. Medical services are organized around individual instances of care, and include providing a cure which involves the doctor taking an active role in healing. The payment of a fee is said to bind the doctor to serve the patients’ interests only, not those of any third party (Sax 1972). The idea that medical services are a personalized service is enforced by asserting the need for specialist interpretation
and emphasizing the uniqueness of the ‘doctor-patient’ relationship. The patient is said to be seen as a whole person and not in the abstract of a disease.

The view that health care is best provided by a collection of individual decisions made by individual doctors in individual contracts is underpinned by a belief in the profession as serving a public good in which the doctor is dedicated to attaining high professional standards in the art of healing, and a belief in medicine as a scientifically validated truth. Accusations of over servicing and over billing must therefore be refuted. While an absence of data makes these accusations difficult to contradict, it makes the status quo defendable. The absence of reliable data ensures the plausibility of the profession’s interpretation, while invalidating others’ claims to authority to speak on such issues. Defusing suspicions of covering up over servicing, the withholding of data is defended by suggesting it protection on civil libertarian grounds.

By insisting that the doctor-patient relationship and confidentiality are imperatives in the practice of the medical exam, the diagnosis and treatment, all of which constitute the medical services delivered by doctors, the public are being asked to enter a contract of trust – the profession will safeguard the medical welfare of the patient using the latest research, training, and technology at its disposal in exchange for the technical, financial, and administrative autonomy. The determination of what constitutes quality in healthcare is linked to the profession’s autonomy. It is this link between professional autonomy and determination of quality which is vital in understanding the attractiveness of the private practice model, and the power of the profession. By yielding on this the profession loses its ability to argue that alternate ways of organizing healthcare are worse than the existing method.

Described as fundamental to the inter-relationships between the patient and his doctor, the confidentiality of information is expressed as ‘the civil liberties of patients and of doctors’ (NAA (c):M4025, 1, AMA reply to the commissions report, p19, paragraph 152, August 1973). Confidentiality and trust are suggested to be linked to medical practice in that patients must not fear seeking advice from doctors and doctors must be free to ask questions necessary for diagnosis and treatment. Often seen as reflected in the Hippocratic Oath as ‘whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets’ (cited Breen,
This ‘obligation’ of professional secrecy is repeated in the World Medical Association Declaration of Geneva as ‘I will respect the secrets which are confided to me, even after the patient has died’ (The Medical Defense Union 1986). Social norms ensure that discussions of the body and its biological functioning are viewed as ‘secrets’. Compliance on these social norms is reached through the ability to explain the cause of illness in such a way that they involve judgment about behavior which may cause embarrassment and social exclusion, and by punishing non compliant behavior.

Doctors claim that confidentiality is an implied term in the contract for services between the doctor and the patient. ‘This contract is based on the fee that patients implicitly promise to pay and for which a patient may be sued’ (Breen, Plueckhahn, Cordner, 1997:40), such a contract does not exist for public patients. The areas of law dealing with confidentiality do little to protect the patient. If the patient sued for breach of contract, or negligence of duty of care – a duty not to give any third party any information about a patient which may result in any loss or damage to the patient - the patient needs to prove that the breach of confidentiality caused some physical or financial harm to the patient: embarrassment or wounded feelings would not be compensable (Breen, Plueckhahn, Cordner, 1997:40/41). While the legal system provides little support for a patients claim when confidentiality is breached, it sanctions the idea that the doctor-patient relationship should be considered confidential in civil courts, except in cases where the sanity of the patient is an issue (See Section 28(2) of the Evidence (Amendment) Act 1984 of Victoria). In a legal sense, doctors are not prevented from sharing patient information with others, yet they are protected from requests to release information held by them about patients. Medical records held by doctors are claimed to be created by treating doctors for their use in the treatment of patients, the legal position concerning the right to access this information by patients in Australia was confirmed by the High Court in 1996 as ‘a claim that a patient has a right of access to his or her medical records is a question of great social importance. Absent a contractual term, such a claim has no foundation in law in Australia (Breen, Plueckhahn, Cordner 1997). Protection from administration oversight and scrutiny in a public healthcare system are protected by law, delaying and resisting Government involvement in managing the direction of healthcare.

Protection of patient privacy was the argument mounted by the profession in support of the protection of information which would provide administrative oversight. There were clear
advantages to the profession of maintaining an argument for confidentiality – it increased the value of the information held in the negotiating position of the profession. Arguing that privacy of medical information would be better left under the current arrangement and should not be trusted to the Government were mounted in an environment of fear of computers and a new Government seeking a great role in the delivery of public services. The AMA needed to be convincing that the benefits of privacy were greater than the benefits of disclosure.

In attacking the computer system and the attempt to collect data on doctors practice behaviors, the AMA appear to understand the extent to which information systems power to document provides it the ability to serve simultaneously as a) a type of technical control of health care costs by the government, b) a political exchange allowing the Government to redistribute power in the name of objectivity, efficiency and equity through the generation of statistics supporting a social epidemiological explanations for the cause and treatment of ill health, and c) as a discourse legitimating the need for continued Government intervention in the control of the direction of healthcare. Information systems as the medium through which power relations create speaking subjects has the potential to support knowledge creation techniques capable of questioning the efficacy of a curative medical approach and the ethics of professionalism. Ideas about information as neutral and objective can be used in support of a view of oversight as necessary to ensure equitable access to medicine and to protect the population from over servicing and over billing. The taken-for-grantedness of healthcare as manageable is supported by information systems. In this way professionalism as a governance mode is undermined while elevating corporatism.

4.4.6 Rules impacting the discursive dialogue

The medical profession which held a monopoly of practice covered by the 1858 Medical Act, had much to gain from Government efforts with respect to legitimizing scientific medicine. The professional association was keen to present an image of the modern medical profession as qualified professional practitioners with a legitimate claim to abstract expert knowledge in scientific medicine, as distinct from commerce-driven quacks. Bourdieu suggests the connection between expert knowledge and economic rewards - it is the impenetrability of expert medical knowledge which authorizes the qualified to speak with authority about what constitutes
healthcare. This authority allows the profession to influence the framing of the problem of healthcare in which the practitioner is instrumental in providing solutions. From the perspective of general practitioners the modern medical professional was a man of science rather than ‘a comforter with an individual knowledge of the patient’ (Roberts, 2009). Despite the familiarity of the mutually dependent relationship between medical specialization and hospital development, the extension of sites (away from the closed shop hospital system) – in Commonwealth Government laboratories - in which to gain specialist knowledge should have had appeal to large numbers of general practitioners struggling to build practices and make it to the ranks of consultant. However, the profession had much to lose from a view of medical practice which did not favour medical services as personalized services. The profession were willing to negotiation a position for preventive medicine in practice as long as the independence of the profession was maintained, ‘curative and preventive medicine … should be kept distinct in any scheme which may be devised to meet present day needs’ (BMA Federal Committee, 1920:42, cited Gillespie 1991, Lewis 2003).

It was not only the medical profession which stood to lose from a view that the expert knowledge of professionals could be directed away from personalized services towards the greater national interest. Lawyers operate in private practices. If the lawyers’ expert knowledge were considered subordinate to the expert knowledge of legislators, private practice may be in jeopardy. Armed with the authority to apply accepted interpretations of the constitution, the judiciary of the high court suggested its meaning was to limit the powers of the Federal Government, and support the powers of professional private practice.

The professions financial, technical and administrative autonomy is granted in exchange for the best approach to maintaining medical welfare. The trust involved and the autonomy granted provide the profession with its status and financial award. The idea that health involves a social network of relationships suggests a shared responsibility in determining the cause and solutions to healthcare problems. Sharing responsibility in defining the cause and solutions to healthcare problems would be an impingement on professional autonomy. Showing a continual bettering of healthcare maintains public support for high standard medical care. By casting doubt on alternative ways of organizing healthcare, showing they can lead to worsening of health services,
public support for the status quo is maintained. Ownership of information which allows for comparisons of alternatives provides the authority to speak on such matters. Bourdieu (1986) refers to cultural capital, or legitimate knowledge, and the battle to control it as important because it influences the occupational structure and therefore the social structure – providing those considered highly skilled with prestige, connections and economic rewards. Presenting the doctor-patient relationship as the only means by which sensitive medical data and the civil liberties of the public could be guaranteed, was made possible by a problematization of healthcare as a personalized confidential service best served by a one to one relationship.

Social epidemiology questioned the link between medical dominance in healthcare delivery and the expert knowledge applied through the techniques and practice of providing medical care. The efficacy of healthcare delivery was being judged by the consequences of interventions on the populations’ longevity and health related quality of life. By calling into question the problem solving activities of diagnosis, medical intervention or treatment through prescription of drugs, the expert knowledge base of the medical profession was being undermined. Social epidemiologists also turned their gaze on the consequences of the system of healthcare on the economy as a whole, and specifically on its impact on measures of health and wealth of members of society: casting doubt on the right of the profession to control the direction of healthcare delivery. Social epidemiology provided economists with authority to speak on such topics as predictability of costs in healthcare and the fairness in establishing common fees – information and data were important components in supporting this area of expert knowledge. It was politics and economics that were directing the use of the technology for the gathering and dissemination of information.

Undermining the legitimacy of the expert knowledge of the professions, and interfering with the public trust placed in this knowledge, was a tactic used by the Government in seeking to establish its role the delivery of healthcare in Australia during the 1970’s. Accusations of over servicing were one such tactic. It served a dual purpose of undermining the trust in the ethical nature of doctoring, using the social scientific demonstrations of economics and statistics to underpin an argument that healthcare was rising in cost without providing improvements in health outcomes. Accusations of over servicing had the added benefit of implying that the States were not managing the distribution of public resources in the provision of healthcare. Without
data such accusations were difficult to refute. An unintended consequence of this tactic was to reinforce a view of the problem of the healthcare system as a technical problem – oversight of professional practice – rather than a political problem of the distribution of power and privilege.

The profession chose strategies which heightened public anxiety about the alternatives to the status quo, exploiting inexperience with centrally coordinated computer systems and the potential for information exposure.

**4.4.7 Rules which ensure that to practice is simultaneously discursive and material**

Avoiding the characterization of the clinical examination as a technical set of procedures – and questioning the reliability of laboratories as an aid to diagnosis – is necessary when establishing the need for specialist interpretation of individual cases. Ethical obligations and legal privilege which involves the right to withhold evidence from discovery and the right to refrain from disclosing or divulging information gained within the context of a special relationship, apply to those between doctors and patients. Confidentiality in the relationship is important when medical care involves intimate and personal relationships which are surrounded by a variety of moral and ethical codes. A view of ill health or disease as being caused by factors which elicit judgment – sexual disease is caused by uncontrolled human vices – encourage a need for confidentiality. The ability to construct an explanation for the cause and impact of illness resides with the profession who create the expert knowledge through research and control of the colleges in which doctors are educated. By denying preventive medicine a place in the university curriculum the scientific credentials of preventive are devalued in comparison to curative. Emphasizing individual responsibility for causing ill health supports the confessional relationship between patients and their illness favoring the trusted doctor patient relationship and the aims of curative medicines. The right to speak on health practice remains in the province of the profession with value placed on personalized services in a confidential private setting.

Expert medical knowledge and therefore medical practice is not a neutral tool in the fight against disease: it is subject to interests, conflict, power and control. Viewed as a social process, the possibility for influencing the value placed in confidentiality and the ‘special relationship’ exists through the social value placed on the expert knowledge which provides the authority to speak
about what constitutes a confidential medical history. Caught within the confidentiality discourse is protection of patient information/details which is represented as a requirement of maintaining confidentiality.

Helping to create the impression that confidentiality should be entrusted to the profession rather than the Commonwealth Government, was the judgment from Rich in the 1949 constitutional challenge to the Pharmaceutical Benefits Act (1947): ‘… the confidential relationship of doctor and patient, a relationship akin to that of solicitor and client and priest and penitent’. The ruling supported the idea that discussing illness and health concerns is essentially a confession. The doctor is cast as the sympathetic expert ethical listener offering protection from the judgmental State. In the event that details of the ‘confession’ are not kept confidential, the doctor is not discharging his professional duties.

Bourdieu (1984) provides a way of understanding what is at stake suggesting that professionals in societies which value specialized expert knowledge can expect to benefit in the form of market opportunities (economic capital) and status (authority to speak or symbolic capital) and work privileges (social capital) (Bourdieu, 1984:96). A view of third parties as interfering in the doctor patient relationship is necessary to ensure the value of confidentiality in medical discussions. Promoting the idea of an interventionist State whose involvement in health was an attempt to erode individual autonomy was a necessary strategy in support of the private practice of medicine.

The value of notifications of diseases continued to be questioned and general acceptance of State responsibility for the control of acute infectious disease was not evident until the 1940’s (Thame 1974, cited Sax 1983). Despite Cumpston’s efforts, public health remained a subordinate function to medical and hospital care in national health policy. Rather than being a tale of medical resistance to State intervention (elements of which do exist here), the beginnings of a Commonwealth Government health department is a tale of medical resistance to practice change and State Government opposition to federalism. The avoidance of government’s attempts to gain administrative oversight into the prescribing habits of doctors in the 1940’s reinforced a view of medical data as confidential between the doctor and the patient. The continued reliance on
doctors for the collection and recording of information as an area of contestation, a contest which takes place under the larger dispute over the direction of the health system shaped the debate in the 1970’s.

The lessons from the 1920’s and 1940’s which illustrated the potential of the doctor patient relationship to instill social control mechanisms, and the use of health as a national security/productivity concern to expand Commonwealth Government power, were applied in the 1970’s. Assuming greater financial administration of healthcare led to the intractable expansion of Commonwealth Government power, yet the position of the States, which maintained overwhelming responsibility for service delivery, was confirmed. During the 1970’s an increased use of external powers through the Commonwealth Government’s capacity to sign treaties, allowed the Whitlam Government to circumvent entangled power relations in the federalist system, involving the OECD and the World Health Organization in disputes concerning the direction of healthcare. This has become an institutionalized way of dealing with conflict when introducing reform.

In the final analysis, Medibank supported ‘sickness care’ over prevention and underwrote the private, fee-for-service system which continues today. To compensate for free hospitalization, hospital agreements committed the Commonwealth Government to paying 50% of the States public hospital net operating costs. The Commonwealth Government paid doctors in private practice, and paid for medical education, while all aspects of legal control of the profession, including registration and fee setting remained with the States (DeVoe and Short 2003). The States became the providers of services, and the Commonwealth Government positioned itself as the purchaser.

At a significant cost, the Commonwealth Government’s position as chief funder of healthcare was given authority to speak on the direction of healthcare, and a voice in establishing the problems and solutions to delivering healthcare services. The unintended consequence of policy was the responsibility for responsibly managing access to affordable services was placed within Commonwealth Government jurisdiction, while control mechanisms for achieving these aims remained within the boundaries of the medical profession.
4.5 Summary and Conclusion

The formation and mutation of ideas supporting an understanding of the need for a national approach to determining the direction of healthcare formed the historical frame for investigation in this chapter. The critical events explored included the establishment of a Commonwealth Government Department of Health, the attempts to nationalize medicine in the 1940’s, and the introduction of a universal health insurance system in the 1970’s. Analysis of the systemization of information focused on contests related to the transition from policy to practice: disease registers deployed in the 1920’s, the pharmaceutical listing in the 1940’s and the Medibank billing system in the 1970’s. The renegotiated systems indicated the point at which the discursive formation is mutated, suggesting the ideas which had diffused into practice, and those ideas which did not.

The analysis of the systemization of information has suggested the possibilities for health information systems in enabling political exchanges through the diffusion of reform ideas into practice. Through the analysis of the transformations of the discursive structures in healthcare, the possibilities of systemized information in healthcare to affect the objects, operations, concepts and theoretical options of the discourse of healthcare have been demonstrated. Analysis of the renegotiated information system paid attention to the ideas which were not diffused into practice, suggesting the constraints in which health policy operates. The analysis also demonstrated the set of rules which define the boundaries in which the discourse of health operates, describing the constraints and possibilities of health policy. Contestation was a regular feature during the transition from policy to practice, despite acceptance of command and control governance modes during much of this period. The analysis has indicated that policy implementation involved renegotiation and compromise. The chronology of the analysis further shows that conflicts were rarely resolved, the negotiations were ‘stop gap’, with the broader aims of reform considered to be delayed rather than achieved.

Analysis of the reform context has highlighted the means by which a climate for change is created in order to influence discursive structures. Legitimizing new domains of expert knowledge provided opportunities to maneuver and shape health discourse. From the beginnings of Commonwealth Government involvement in controlling the direction of health, disputes over
claims to expert knowledge on medical practice surfaced. The analysis has suggested the possibility and limitations of systemized information to undermine the established view of curative medicine as a professional personalized service involving expert knowledge and confidential interactions. Further the analysis demonstrates the ideas which information systems have diffused into practices reflect the accord reached over the reforms to governance. The analysis makes visible the ideas which have failed to diffuse.

Acceptance for a nationally co-ordinated approach to the delivery of healthcare is an idea which has been difficult to implement into practice. The political exchange required to migrate from professionalism to corporatism as the dominant governance mode in healthcare was at the centre of reform efforts explored in this chapter.

The deployment of disease registers in the 1920’s marks a point of transition from policy to practice. Disease registers involved recording, categorisations, and disseminating disease information in a systemic way and their deployment caused a disruption to the health discourse. The conflict over disease registers was a contest between those who viewed the practice of medicine as a scientific pursuit involved in preventing disease and those who viewed the practice of medicine as a personal service involved in curing ills. Engaged in a contest about how best to practice medicine and deliver health services, disease registers became the point at which the accumulated conflict created by the Commonwealth Government assuming a role in the delivery of national services was expressed. The negotiated solution was the two system approach to providing healthcare in which publicly supported population healthcare embracing preventive medicine and privately provided personal healthcare embracing curative coexisted. The two system approach to healthcare and an understanding of prevention as a public health concern are two ideas which became diffused through the practice of systemizing information in the form of disease registers.

Governance reforms in the 1940’s were also facilitated by the processes for legitimizing new areas of expert knowledge. The introduction of antibiotics and effective therapeutic medicines in the 1940’s triggered Government action in seeking to regulate the prescribing habits of doctors through the standardization of procedures for prescribing. Pharmaceutical formulary’s involved
recording, standardizing, and disseminating treatment information in a systemized way, and their deployment disrupted the discursive space in which health operated. During this period the ideological conflict between provision of health services in the public versus private sphere subsumed the more localized professional debate over the risk of encouraging patients to rely on therapeutic medicines as a cure to illness, and understandings of illness as a form other than divine retribution. The same contest waged in the 1920’s over how best to practice medicine and deliver health services was repeated, the introduction of a pharmaceutical formulary became the point at which the accumulated conflict created by the Commonwealth Government expanding its role into provision of social services and welfare was expressed. The negotiated solution supported the position of privately provided curative medicine by endorsing the idea that doctor controlled health information was central to the doctor patient trusted relationship. The scope of public health was extended from prevention to acute care allowing for publicly provided life saving and disease-preventing drugs. The idea of essential curative medicine as a community concern, and ideas about central coordination to gain access to essential services were diffused through the practice of systemizing information in the form of pharmaceutical formulary.

The other major rupture to the discourse of health that was investigated in this chapter occurred in the 1970’s when debate centering on the efficacy of scientific medicine became subsumed by the larger debate over equitable access to healthcare. The contest at this time focused on how best to deliver health services, with debate over how best to practice medicine playing a minor role. The difficulty of implementing policy necessitated this focus. The introduction of the Medibank billing system became the point at which the accumulated conflict created by an expanding Commonwealth Government role was expressed. Building on the idea of essential curative medicine as a community concern, and ideas about central coordination to gain access to essential services, the negotiated solution provided public funding to fee-for-service curative medicine providers. The enduring legacy of the ideas diffused into practice through the systemization of health costing information was the impression it created that health could be managed through tighter administrative oversight, implying a ‘right’ mix of services which could be controlled when information is made available for analysis. Ideas about privacy of patient data as vulnerable to exploitation were formed during this period.
Unresolved conflicts and stop gap negotiations mark the transition from policy to practice in determining the best way to practice medicine and deliver health services. Systemizing information to diffuse reform ideas had mixed results. Enduring is the idea that the medical professional is pivotal in health information collection and dissemination.

The constraints and possibilities for influencing the health discourse have been analysed. The analysis suggested that the mutually interdependent relationship between the Government as purchaser and the profession as provider was made possible by a view of central management as constrained by information flows controlled by doctors. The idea that the medical professional is pivotal in health information collection and dissemination, an idea which was diffused during this reform era, informs the history of the present.

The analysis has suggested that diffusion of ideas via practices of systemized information is difficult and can produce mixed results. The analysis also suggests that the unintended consequence of failing to diffuse key reform ideas strengthens existing institutional arrangements. The translation of policies into practice, particularly where information systems are involved, was problematic during these periods of reform even though command and control governance modes were accepted. The social, political and economic context which influence how the problems and solutions to policy problems are framed, also influence policy implementation negotiations involving the systemization of information.

Analysis of the renegotiated information systems as the site which indicates the point at which ideas are diffused into practice, provided valuable insight into the policy implementation process as complex and fraught. The focus of the following chapter will be a localized analysis of an information system into the health system - the implementation of Casemix IS in Victoria. Chapter 5 will explore how the ideas about healthcare and the management of healthcare formed during the periods of reform discussed in this chapter constrained and opened up opportunities for influencing power relations in healthcare. Policy as discourse will provide the analytical framework through which the analysis of the transformative effects of policy on the discourse of healthcare will be investigated.
Chapter 5

Introducing Casemix 1993

5.1 Introduction

This chapter will focus on gaining an understanding of the climate for change that existed, and the ideas that were being diffused, during the deployment of systemized information in the form of Casemix, a hospital reimbursement system geared to output and supported by IT, in the first half of the 1990’s. In 1984 Medicare was introduced, returning stability to the universal health insurance scheme. Public interest in Medicare and a return to a universal scheme was widely credited with Labors election victory in 1983 (Bloustien, Comber, Mackinnon 2009). It was during the 1990’s that the Government had again to meet the challenge of legitimizing a role for itself in the management of healthcare. The migration to a market society and changed understandings of the role of Government challenged notions of Government provided services.

The chapter is concerned with how the discourse of health was changed as a result of the ideas diffused via Casemix and the constraints placed on alternative ideas by systemized information. This chapter will interrogate the amalgam of policy tools which make up the policy technology deployed in support of competitive structures in the delivery of health services during the early 1990’s. The focus remains on how the problem of health was created, how alternate explanations were constrained, and how potential solutions were positioned and eventually taken-for-granted. The ideas which were not diffused and which required renegotiation is of particular interest. In an attempt to understand ideas formed about systemized information in healthcare which constrain current understandings, various interpretations of Casemix will be described.

To this stage the study has described various attempts to define a role for the Commonwealth in a nationalized health system which occurred in the 1920’s, 1940’s and the 1970’s. The role of systemized information in support of reform during these periods was described, and how the discourse of health was mutated through the diffusion of ideas via systemized information was
analyzed. The problem of healthcare as a technical issue of managing the right level of affordable service was a Commonwealth responsibility, despite the Commonwealth lacking legitimacy for policy tools which would allow it to accept this responsibility. Creating a climate for change in a market society to create the possibility to affect a change in governance mode from professionalism to corporatism can be expected to require more sophisticated tools than command and control. This chapter builds on understandings offered in the previous chapter about ideas formed about information and use of systemized information in diffusing reform ideas. This chapter attempts to interpret strategies used in creating a climate for change in a market society as a precursor to a detailed description of the current reform environment.

The potential of Casemix to resolve healthcare problems required hospital administrators to conceive of the administration of health as active in delivering outcomes. Told through the recollection of practitioners, this chapter will principally describe the experience of hospital administrators present during the implementation of Casemix in Victoria in the early 1990’s. The experiences of peripheral players are also considered. In an attempt to understand the translation of policy to practice, the implementation of systemized information in the form of Casemix is conceived as a critical event. In this study critical events demonstrate the redefinition of the realm of central control in the management of healthcare. The implementation of Casemix will be used to develop an understanding of the effects on policy parameters, particularly in relation of the systemization of information. This chapter will contextualize the deployment in the bigger picture reforms, specifically the political influences, to gain an understanding of the framing of the problem of healthcare and the positioning of information in suggesting possible solutions. Set within a period in which the political debate over public ownership of economic goods was considered over, the changing role of the Commonwealth Government, and the way in which its boundaries were defined will be examined.

This chapter will begin by exploring the environment which existed during the introduction of Casemix. Utilizing the analytical framework outlined in Chapter 3, this chapter will describe changes to the position occupied by the speaking subjects in healthcare, changes to the boundaries in which health is recognized to operate, and changes in the creation and dissemination of information about healthcare. The chapter concludes by analyzing the set of
rules which determine the discursive space in which healthcare operates following this period of reform. The impact of diffused practices on current reform efforts will be explored.

**Data introduced in this chapter**

In describing the environment for change that existed at the time, interview data is drawn on. Practitioners recall their experience during the introduction of Casemix. The role of hospital administrator was changed to become influential during the period in which Casemix was introduced. Degeling, Sage, Kennedy, Perkins and Zhang (1999:174) noted that ‘prior to the 1990’s what had been termed ‘hospital administration’ was procedural and negotiative in character and directed at accommodating and /or balancing the often conflicting demands of different professional groups. In contrast, newly appointed hospital managers were expected to be more tightly focused, proactive and directive. They were also expected to have a specific concern for improving performance on output targets, strengthening the accountability of clinicians and controlling their financial performance’. Every attempt was made to identify and interview those who were newly appointed administrators at that time – and who had a continued involvement in healthcare - as they could be considered active in the discursive formation process. Four Victorian health administrators who held senior roles during the introduction of Casemix, three of whom were newly appointed, discuss their experiences during this period of reform. The current CEO of Health Association of Victoria who was a newly appointed administrator at a rural hospital at the time Casemix was introduced, the current Director of a health consultancy firm who was formerly a newly appointed CEO of a public hospital, the current Director Center for Online Health who was a newly appointed Executive Director of an Extended Care facility in Victoria throughout the 1990’s, the CEO of General Practice Division who had recently moved from the Victorian Department of Health to the General Practice Divisions during the Casemix implementation, and a Director of the Royal District Nursing Service who was working with a health services software solutions provider at the time of Casemix, provide the rich data concerning the deployment of Casemix for this chapter. Numerous attempts to secure an interview with Stephen Duckett, health economist and architect of Victoria’s casemix funding model - were unsuccessful. All people who co-authored articles with Stephen Duckett in relation to Casemix between 1993 and 1995 were contacted: those who
responded positively were interviewed. Documents obtained by the researcher under the Freedom of Information Act (1992) also inform the discussion on Casemix in Victoria.

This chapter draws on data from documentary sources, including government policy documents, government discussion papers, departmental records and reports, annual reports of significant institutions, commissioned reports, Australian Bureau of Statistics data, Australian Public Service database, media releases and meeting minutes, and secondary sources such as newspaper articles and academic literature.

5.2 Background

The resolution of the conflicts of the 1920’s, 1940’s, and 1970’s which sought the expansion of Commonwealth government involvement in health, diffused ideas about central administration in the management of healthcare and information in practice. Notions of affordable quality healthcare as a right of citizenship were taken-for-granted, granting the Commonwealth legitimacy in the role of ensuring access to healthcare, while the profession delivered services in a fee-for-service model. The idea that a national health system could be and should be managed by the government was accepted. Ideas regarding the necessity of a two systems approach to delivering healthcare shaped the context of health services so that preventive medicine existing in the sphere of public health, and curative medicine fell within the jurisdiction of the private fee-for-service model. Considered pivotal in health information collection and dissemination, the impression that the management of healthcare was constrained by information flows controlled by doctors had been formed. Many of these ideas were incompatible with notions of a market society.

In line with other OECD political economies in the 1980’s and 1990’s, Australia pursued dual policies of decoupling of governments from provision of services and pursuing economic competitiveness. The approach taken was for government to retain centralized strategic control over policy, performance targets and resources, while operational decision-making and service delivery is decentralized – referred to as ‘government at a distance’ by Rose and Miller (1992). Divorced from the direct responsibility of providing public services, the government assumed a narrow focus of running the economy (Pusey, 1992). The impact was the creation of a role for
the Federal Government in which it steered service provision, rather than acting as a provider, through the use of economic efficiency and effectiveness measures (Lingard, 1990, 1991, Bartlett Knight, Lingard, 1991). Placing key public services within the jurisdictional boundaries of the Federal Government in the new market led economy subjected these services to measures of economic efficiency – healthcare was not to be exempt from microeconomic reform (Scotton and Owens, 1990).

Along with education, health remained a residual constitutional power of the states, with shared funding responsibility between the Commonwealth and State governments. The Hawke labour government reintroduced Medibank as Medicare in 1984 following the Fraser governments attempt to dismantle the system. In a speech to the Health and Research Employees’ Association on 5th March 1984, the Prime Minister Bob Hawke indicated a move away from viewing health as purely a social justice issue and remnant of the welfare system, a view that healthcare was a right of citizenship tied to the individual’s economic welfare, involving ‘essential’ treatment, was formulated:

All Australians are guaranteed – as a basic right – protection against the financial impact of essential medical and hospital treatment
(Hawke, 1984)

The move from ‘equitable’ access to essential access was being proposed. The move towards individual responsibility for ‘non essential’ medical treatment is implied. Hawke was at pains to express the view that Medicare as a financial/economic issue which required government oversight to protect the public from over servicing and inefficiency in state government process:

The upward trend in costs needs to be recognised. Health costs as a percentage of Australia’s National Product increased substantially during the 1970’s – rising from over 5.7 percent to 8.00 per cent of GDP in the period. Many factors were responsible for this’ some of these were socially desirable and necessary – for example the equal pay decision of 1973: other elements, such as those involving medical fraud and over servicing, were a heavy drain on the public purse. What is clear is that Governments must take vigorous and effective action to contain increasing medical service costs to the extent possible. We are also committed to containing costs on the hospital side of Australia’s health budget. Unlike the hospital funding arrangements under Medibank and in the early Fraser years, we will not be sharing the costs of State hospital systems on a
dollar for dollar basis. The open-ended commitment involved in the system considerably reduced the incentives for State Governments to contain the costs of their hospital systems. (Hawke 1984)

Hawke was committing to an effort to nationalise health care expenditure while distancing the government from a role in nationalising healthcare – public support for the restoration of Medicare had significantly contributed to Hawke’s 1984 election win. Indicating the desire to move from professionalism as the governance mode operating in the healthcare sector to a corporatist governance mode, Hawke makes explicit reference to fraud and over servicing as the cause of increasing healthcare costs. Strong financial management is suggested as the solution to healthcare problems. Utilising budgetary control of Medicare to apply pressure on the States and the profession to change behaviour was being suggested.

During the 1990’s, the State and Territory governments were responsible for providing public hospital services, the private hospital sector has been largely deregulated, and medical services were provided to patients by doctors who are in private practice and who had therefore no contractual arrangement with the Commonwealth covering either the quality of the service or fees that doctors may charge. The National Competition Policy (NCP) (1995) was an agreement between the Commonwealth and State governments which committed them to microeconomic reform covering both business behaviour – through trade practices legislation – and government activities. Changes to legislation saw professional services covered under the Trade Practices Act (1974). The Act set out the disciplinary framework for anti-competitive agreements and exclusionary provision (Trade Practices Act, Amendments 1995). The National Competition Policy (1995) focused on promoting efficiencies in the public sector and reducing costs for the private sector, in respect of input costs such as electricity, and lower compliance costs (Harmen 1996). While the states had been involved in microeconomic reform agendas of their own throughout the 1980’s and early 1990’s, the national competition policy coordinated all activities under a national agenda. The NCP provided the Commonwealth with the capacity to apply pressure on the states, shaping their behaviour (Hollander 2006). A focus on ‘value for money’ in the business of managing public health expenditure had come to the fore (Considine and Lewis, 2003).
5.2.1 Positioning Casemix and Output Funding

The task of measuring the quantifiable economic value of hospital care through systemization of information practices began in earnest in the 1990’s with the deployment of Casemix. The Casemix system envisaged for (and eventually deployed in) Australia uses the Diagnostic Related Group (DRG) classification system - the purpose of which is to categorize patients according to the intensity of resources used in their treatment (Palmer 2001) - assigning costs to the groups, measuring hospital output and activity as well as being a method for determining funding and incorporating quality monitors (Palmer, 2001). Casemix is involved in keeping track of resource usage. Information becomes available for evaluating the cost of clinical procedures and guides resource allocation decisions. DRG and Casemix include standardization classifications of admissions, treatment, length-of-stay and discharge decisions (Chute, 2001). As a health management tool, patient data is recorded, categorized according to diagnosis and procedure undertaken, aggregated with financial data about resource use, and disseminated to allow for differentiation between high and low cost care. The systemization of information in this way provides oversight of resource usage and practice decision making, and allows for health care to be included in discussions of economic development.

A project funded by the Commonwealth into the role of economic incentives for increasing hospital efficiency resulted in a study by Richard Scotton and Helen Owen ‘Case Payments in Australian hospitals: Issues and Options’ (1990). The focus for the Commonwealth was on the role of Casemix as a reimbursement system geared to output, which would ‘result in more efficient performance than other formulae’ available in the 1980’s (Scotton and Owens, 1990:183). The purpose of implementing ‘DRG’s and other output-based case payment formulae is to induce changes in behaviour and decision making, which will have structural and organisational consequences throughout the system’ (Scotton and Owens, 1990:183). The desirable outcomes expected from Casemix were behavioural changes which would lead to structural change.
Essentially, case payment has to be seen as a potential item on the agenda for microeconomic reform. There is no reason why the healthcare system should be exempted from this process. The basic reason for the lack of progress in the past has been the inability to measure output, DRG (*diagnostic related groups*) is a workable proxy for output, the technical obstacles have been substantially overcome. (Scotton and Owen, 1990:184).

Describing the lack of competitive structures in healthcare as a technical issue of metrics, Scotton and Owen (1990) advocated the use of DRG’s. Explicitly suggesting ideological detachment from a role for government in providing services, Scotton and Owen (1990) imply that a technical metric will provide the neutral evidence necessary to bring about change to institutional arrangements. Highlighting the impact on productive and allocative efficiency, structural changes would occur as ‘reduction in inputs such as drugs and tests not justified by prospective outcomes’ will account for ‘shifts in care from more expensive to less expensive and increased productivity levels’ (Scotton and Owen 1990:187). Scotton and Owen (1990) were suggesting that professional decision making and professional practice would be shaped by an understanding of the problem of health care as a resource utilisation issue. A key priority was recognised to be the establishment of an information system at individual hospitals to collect and record in computerised form, data sets providing information necessary to classify all inpatient episodes and the capacity to transmit necessary subsets to State and Commonwealth agencies for payment, review and statistical purposes (Scotton and Owen 1990:196). Key indicators of efficiency are considered to be the Average Length of Stay and number of discharges (relating to the activity volume of the hospital). The problem of funding healthcare was being translated into one of a lack of the appropriate information to direct resource utilization (Doolin and McLeod 2005:251).

The capacity to implement the Commonwealths overarching agenda of supporting competitive structures in healthcare required the States to exert influence on hospitals. The relationship between State governments and hospitals was complicated during the 1990’s. Participants MA3 and CR5 describe:

…some of these hospitals are very big powerful organizations with influential people on their boards. In those days the minister didn’t appoint the boards, they were elected. So
you had a much more independent feeling set in hospitals and I think that has continued to now. The department is always quite timid in its relationship with the organizations that it funds.
(CEO General Practice Victoria, MA3)

Looking back, hospital boards were quite powerful, they would tell the Government what they thought publicly. It was quite uncomfortable for the Government and the department.
(Director Health Consultancy agency, former hospital CEO, CR5)

Describing aspects of the institutional arrangements which supported the professions monopoly position in the delivery of healthcare, the difficult negotiating position of the State government in affecting reform is highlighted. Implicit in these responses is the suggestion that political will was needed to persuade hospitals to recognise their accountability to the State Government as the funding body.

Strengthening State political resolve the Commonwealth used budgetary control and performative measures throughout the 1990’s to influence the States to implement policy initiatives, while dangling the threat of Commonwealth takeover. Participant (MA3) discussed this saying:

In 1975, there were no measures of any kind what so ever. If you went over budget you wrote to the department and said we seem to have a bit of a deficit could you top us up and they would. … The relationship between the Commonwealth and the State was quite good then. It was a different relationship. When I went to Canberra in the beginnings there was no attitude that we are Canberra and the States are hopeless, an attitude that pervades at the moment. When there was a lot of money in the early days, you don’t have a problem. When the Commonwealth reigned in their budgets you get the departments taking on the colours of their political masters.
(CEO General Practice Victoria, MA3)

Describing the impact of performance measures as painting a picture of inefficient, ineffective State Governments, MA3 highlights the position of strength assumed by the Commonwealth Government through its control of reduced health budgets upon which the States were reliant. MA3 suggests that Commonwealth budgetary control was used to direct the actions of the States.
The respondent implies the creation of healthcare as an economic issue in order to direct the activities of the State governments.

In the early 1990’s, skills in Casemix were developed in Victoria. Early examples included Palmer’s (1992) report comparing the length of stay by DRG for Victorian and Maryland (USA) hospitals with the objective of this data being used by hospital medical staff to influence decisions about the duration of hospitalisation (Palmer 2001). The intention to use comparison data to allow for judgement of professional decision making about the right way to practice was being suggested. The imposition of administrative technique on medical care decisions was being trialled.

A new state government in Victoria (1992) espoused the value for money in public services ethos: ‘The whole culture of the public service is being remodelled to deliver quality services within budget constraints. We have developed the MII (Management Improvement Initiative) to re-engineer the government’s management systems and budget processes to establish an efficient, reliable framework for the corporate management of the state – which is a $17 billion a year business’ (Kennett, Premier of Victoria, cited Alford and O’Neill 1994:74). In 1993 output-based funding was introduced in the form of Casemix and deployed through the practice of systemization of information in which clinical coding of patient data categorized according to diagnosis and procedure undertaken, aggregated with financial data about resource use, and disseminated, was undertaken in the Victorian hospital system (Duckett, 1998).

5.3 The Displacement of Boundaries

Reforms aimed at elevating the position of efficiency and at promoting a view of quality health outcomes as cost efficient reshaped professional boundaries, converging administrative and professional practice. Participants discuss the impact Casemix had on reshaping of professional boundaries to allow other voices to influence an understanding of health outcomes, and the role of statistics in supporting new ways of understandings healthcare.
5.3.1 Constraining opposition to administrative reform

Casemix granted legitimacy to the administrative tools of professional administrators, and in turn to the role of administrator. Speaking of the efficiency arguments underpinning Casemix, a former hospital administrator suggests Casemix supported the professional ideals of administrators, e.g. respondent MA4 said in interview:

I think there was acceptance that it was technically efficient. From a professional viewpoint, administrators could sort of understand the hypothesis underpinning it. Professionally it was hard to dispute: it was well rounded in research. Well rounded in how those things connected up.
(CEO Victorian Healthcare Association, MA4).

Describing research methods which support claims to expert knowledge, MA4 emphasises the legitimacy afforded to the administrative techniques supported by Casemix. MA4 identifies Casemix as a rational tool for administrators which supported decision making based on professional administrative ideals. The constraint imposed on opposing views by applying the epistemological demonstrations valued by the professions to administrative techniques is suggested. Implicitly the respondent suggests Casemix provided an understanding of healthcare consistent with administrators’ views.

Confidence to express the administrators’ viewpoint was also recognized by a former hospital CEO as a benefit of Casemix, who suggested in interview:

The economics part of it and the understanding of the financial side and efficiency side is something I’d always believed was lacking in the hospital system. There was this sense that it was money versus quality. My view was the thing should be economically efficient. If it was economically efficient you could produce more goods, more outcomes, more services.
(Director Health Consultancy agency, former hospital CEO, CR5)

Describing a need to understand healthcare as a manageable service which should be subject to administrative techniques, CR5 suggests the disparate views that existed within the hospital system and the desire to change understandings.
The legitimacy of health economic statistics as an area of interest in healthcare nationally was only formally acknowledged in 1991 with the establishment of the Center for Health Economics Research and Evaluation (CHERE University of Technology Sydney, Faculty of Business). The Center for Health Economics (Monash University, Faculty of Business and Economics) was established in 1992, and the introduction of Master in Health Economics at University of Queensland (Faculty of Business, Economics and Law), Australian National University (College of Business and Economics). The discipline remained within the boundaries of Economics and Business.

Research funding in healthcare was controlled by the NHMRC which had extended its influence with the introduction of the requirement that any institution that conducts research on humans had to conform to a review by an institutional ethics committee (IEC) (Drahos, 1989) a position supported by the introduction of invitro fertilization (1985). The guidelines for the IEC’s were established by the NHMRC. The extension of ethical review of research to include social and behaviour research was achieved by: ‘defining planned experiments as ranging from those undertaken as a part of patient care to those undertaken either on patients or on healthy subjects for the purpose of contributing to knowledge, and include investigations on human behaviour’ (NHMRC 2010). In order to receive funds for research from the council, a review by an IEC was required (NHMRC 2010). Funding of health economics as a research category is first mentioned in NHMRC funding documents in 1995 when $320,230 was allocated from an overall funding allocation of $130,040,295 (NHMRC 2011a). The Research and Development Grants Advisory Committee provided health services research funding until it was absorbed by the NHMRC in 1997 when its budget was $745,000 compared to medical research funds of $154 million (NHMRC, 1997). The funding for much of the advancement of health economics in the early 1990’s was provided outside the NHMRC: ‘The health authorities, and sometimes hospitals, also fund centres for this type of research (e.g. the Centres for Health Economics Research and Evaluation and Effective Health Care in Sydney, the Centre for Social and Economic Modelling in Canberra, the Centre for Health Program Evaluation in Melbourne and the Menzies School of Health Research in Darwin)’ (Wills, 1999:92). Health economics was under presented in NHMRC approved grants, explaining it’s positioning within the disciplinary boundaries of Economics and Business.
The relative infancy of Health Economics as a professional discipline capable of influencing policy is stated in CHERE’s 1994 annual report:

The setting and circumstances under which health economics is relevant and used by health care planners, policy makers, and managers, are not well identified. CHERE aims to identify appropriate opportunities. The application of economic evaluation methods is one avenue.


Describing health economics as outside the structures supporting institutional arrangements, evaluative methods were proposed as a role for health economics within supporting structures. The direction of early health economic research efforts is indicated by the refereed journal articles attributable to the research centers in 1993. Understanding the behavior of individuals and optimal resource allocation provided the focus.

Casemix which had attracted research funding via the Commonwealth government, contributed to the legitimacy of the field of health administration and to health economic statistics. Participants suggest that it was supporting an understanding of health as a manageable service which could be improved by applying supply and demand levers.

5.3.2 Administrators and the responsible management of budgets

The ability to influence practice and clinical behaviour in a cost conscious way was the strength of Casemix envisaged by Scotton and Owens (1990). To achieve the dual aims of managing the costs of healthcare while taking a distance from direct service provisioning, the role of hospital administrator was targeted and became subject to accountability measures for the responsible management of budgets in exchange for autonomy. Two participants involved in hospital management during the introduction of Casemix describe in interviews the environment at the time:

…that was the attitude of the Kennett government – here’s the money, here are the rules, now you go away and deliver and if you don’t we’ll get rid of you. There was more
capacity for management to make decisions autonomously and I guess that ended up being quite a feature of the Victorian landscape of health administration. (CEO Victorian Healthcare Association, MA4).

The administrators’ primary focus was on their relationship with the department. They were saying we are under enormous pressure from above to have to produce or get out. (Director Health Consultancy agency, former hospital CEO, CR5)

Highlighting the clear divide between the roles of purchaser and provider, MA4 and CR5 describe hospitals as subject to corporate control mechanisms of budget control, accountability and performance metrics. They suggest that administrators’ autonomy over work and work processes, which is a hallmark of the professions, was conditional on meeting corporative objectives. Explicitly voiced in these responses is the understanding that by influencing administrators, State governments sought to implement the Commonwealth Government’s overarching agenda of introducing corporate competitive control mechanisms. MA4 implies the political economy of hospital administrators under a corporate governance mode was enhanced.

Accountable for managing responsible budget, the administrators who worked for the hospitals could directly impose the cost control measures driven by budgetary cuts. A former hospital CEO and former director of an extended care facility said:

The message changed from ‘have a full hospital and get a bigger budget’ to ‘run an efficient hospital and perhaps even reduce your cost’ … We ran the limited funding line, and they got it. ‘If you believe in your hospital and you want your hospital to survive, this is the new system, this is what we’ve got to do.

(Director Health Consultancy agency, former hospital CEO, CR5)

To get ownership at the clinical level there are a number of devises. One example you say ‘well the hospital budget’s going to get cut and you’ll be worse off’, ‘you’ll have to put staff off, it won’t be much fun working here, that kind of thing’. Managers try to drive this down to divisional level, to unit level. You can try and get people to cop it, some buy it some won’t. It depends on whether they see their job as secure. Casemix became part of the thinking of what you were going to do.

(Director Center for Online Health, former Executive Director, Extended Care Centre (MR6)
Describing the authority assumed by administrators in implementing reform, CR5 and MR6 suggest the change in funding mechanism and possible closure provided the impetus for change. The respondents describe the coercion of the profession to adapt to changed circumstances understood in financial terms. What is emphasised here is that administrators as agents of the Government relied on formal resources of legitimacy and authority – funding – to manage the involvement of the profession in reform.

5.3.3 Administrators and the right to speak about practice

Casemix was providing the mechanism for hospital administrators to speak on the right way to practice. MA4 and CR5 suggest:

... it certainly sharpened thinking because the whole funding model was based upon inliers and outliers and therefore there was an expression of what the expected length of stay looked like. It became a tool to educate medical administrators around the correlation between cost and length of stay.
(CEO Victorian Healthcare Association, MA4)

Where I was we said we have to reduce length of stay and the doctors said ‘well, normally we keep them in an extra day just to be sure’. Our average length of stay was four days, they were really cooperative. From June to July we took our average length of stay from four days to three.
(Director Health Consultancy agency, former hospital CEO, CR5)

Administrative tools afforded administrators visibility into patient care practices, which had previously been exclusively in the realm of the profession. Decisions to admit patients to hospital and discharge patients from hospital relied on medical professional judgement. The potential Casemix offered to apply a financial administrative framework to medical judgement is highlighted in this response. MA4 and CR5 suggest the scrutiny applied to clinical decision making surrounding length of hospital stays from outside the professional boundaries. The impact of measuring length of stay on understanding healthcare as a financial management issue and amenable to administrative techniques is expressed. Implied is the role supported for administrators by Casemix in challenging medical professional decision making.
Rather than prescribing the decisions which should be taken, Casemix supplied performance data which would cause the profession to re-evaluate their performative worth. A former hospital CEO details how performative comparison data was utilised:

> My view was never that we were telling them what the length of stay would be. We were telling them what the average length of stay should be. I don’t think a lot of doctors get access to information about where their performance sits amongst their peers. Where they do, I think that is quite powerful.

(Director Health Consultancy agency, former hospital CEO, CR5)

The application of Casemix to provide comparison data is described as an effective tool in changing behaviour. The respondent suggests administrators determined the area for behavioural change by setting the average, encouraging a reading of average as the ‘norm’. Implied is that deviation from the norm would require the profession to question their decision making and bring about behavioural change.

The use of Casemix to allow for comparison data to be analysed was recognised by MA4 as applying administrative practices to bring about professional practices change:

> Introducing Casemix really gave the capacity to link up that technically efficient analysis around well ‘here is the average cost weight for hospital A at .8, and at hospital B it is .9, and they both do the same amount of separations. Now we understand why hospital B costs more because they have a higher level of complexity than hospital A’…looking for a way to understand variances in cost and variances in performance as a result of that cost driver.

(CEO Victorian Healthcare Association, MA4).

Suggesting that the medical professionals’ scientific based decision making should result in limited cost variances between similarly active hospitals, MA4 highlights comparison statistics as the tool used to question professionalism as a governance mode. The practices of the profession and professional decision making were to come under the gaze of financial administration via Casemix. Performance metrics based on an acceptable level of performance for an acceptable price was to be applied to the profession.
The ability to apply comparison statistics to create an understanding beyond the rational allocation of resources was acknowledged. The use of statistics to include a role for comparison data as a disciplinary tool to influence compliance with standards and influence the structures which support the medical professions monopoly in healthcare was highlighted by MA3:

… people would look at it to say this doctor or that hospital is performing better than the others. It is always going to be taken, particularly by the media, as now we know who is hopeless let’s get stuck into them. Rather than now we know who is not doing as well as they could, let’s help them lift their standard. That is the problem with it. These simplistic tables don’t help, it just encourages the public to think in those sorts of terms. It’s a league table. The spirit with which these things are used is the key to it.
(CEO General Practice Victoria, MA3)

Describing the punitive response to comparison data which identifies under performing hospitals and doctors, MA3 suggests an understanding of variation as synonymous with inappropriateness and as requiring of corrective intervention. The judgement applied to comparison statistics is suggested as creating the impression that the problems of healthcare are simply a matter of resource over utilisation and can be addressed through administrative techniques, in support of a corporatism governance mode. Implicit in the response is an understanding that scrutiny of performance from outside the professional boundaries is impacting the autonomy of the profession. MA3 suggests the professions right to speak on quality healthcare has been impacted by Casemix comparison data.

A doctor manager (MR6) who was a director of an extended care facility when Casemix was introduced describes the impact on the value placed on the performative worth of the professional:

You compare yourself to your peers. The average this year will be a bit shorter than the average last year. You never quite make it. That is the kind of world Casemix creates. You get some strange ways of thinking. Some people began to think that Casemix was like the eleventh commandment. There was an ethical and moral dimension to it – if someone left with the right length of stay the world was a better place.
(Director Center for Online Health, former Executive Director, Extended Care Centre (MR6)
Casemix as a disciplinary tool is described. MR6 describes the professions practice as judged by metrics which are unattainable, causing them to assess their own behaviour in relation to targets, limiting discussion on the appropriateness of the targets. Suggesting the length of stay targets have gained acceptance as the right way to practice, and in some quarters as irrefutably the only way to practice, the profession as subject to the disciplinary techniques of Casemix impacting on the professions autonomy is implied.

5.3.4 Administrators and the right to speak about quality

Providing administrators a voice in questioning the practice of care extended the scope of Casemix from expenditure to quality, as MA4 suggests:

> it became a tool to say ‘well if length of stay is consistently longer than what we would expect, is that an indicator that we’ve got some poor quality in our clinical delivery system.
> (CEO Victorian Healthcare Association, MA4).

Described as a measurable standardised service, the ‘scientific basis to much clinical decision-making’ (Duckett, 1995), could be monitored. Providing a mechanism for questioning the quality of medical professional services, Casemix was questioning professionalism as a governance mode. The response highlights the use of Casemix as a disciplinary tool to influence behaviours. The respondent suggests the judgment applied to clinical performance according to administrative performance criteria, through administrative practices. The response indicates that administrative accountability was being applied in the governance of the profession and the sector.

The emphasis of Casemix on describing standardised services as products extended the definition of quality clinical service to include cost measures focussing on acute care. A director of RDNS explains:

> …we’ve got a minimum level of care that we need to provide and we have to base that around clinical information If you should be able to do a hip replacement with x number of professionals and time in hospital and get the person out the door and back on with
their life in a certain amount of time for a certain amount of money the pressure of saying ‘well that’s the way we’re going to fund it because that is what we need to achieve’ is also pushing a clinical level.
(Director Royal District Nursing Service, MA2)

The respondent describes the accountability practices governing resource utilisation as subjecting professional activities to corporate control mechanisms. The dissociation between task and the doctor patient relationship encouraged by Casemix is emphasised. The clinician is encouraged to examine their actions in terms of an accepted norm set for a task, and take action to achieve the norm. MA1 suggests the clinicians’ actions are constrained by a financial imperative set by the Government, in this way the use of Casemix is seen as a disciplinary tool to influence behaviour. The response suggests the quieting of resistance to reform by rational technically efficient methods which supported an administrative view of healthcare as a financial management issue. MA2 describes the potential dominance of corporatism as the governance mode in healthcare. It is implied that a minimum clinical standard is achieved.

As a standardised service a scientific haze was afforded to efficiency data, quietening opposition to the evidence of outputs. A former hospital administrator states:

There is only one way you can do a hip replacement. That was the technically efficient aspect I was referring to. People really couldn’t argue with some of those hypotheses that were underpinning Casemix.
(CEO Victorian Healthcare Association, MA4).

Describing the application of administrative judgement to the practice of medicine, MA4 suggests that professional judgement was being undermined by a view of professional practice as a product subject to efficiency measures. The respondent describes medical practice as the application of technical skill, distancing it from the art of curing. The response implies that professionalism was being made subordinate to corporatism through Casemix.

5.3.5 Healthcare as a problem of resource utilisation

Stripped of its complexity, health as an economic good presents the problem of healthcare as inefficient resource utilisation. The solutions proposed attempt either efficient resource use or additional resources, in both cases placing health under administrative control. MA2 describes:
Casemix does tend to, from what I can see, you’re in for a hip replacement this is the care path for you – that is what hospitals are, they are factories for getting things done and providing treatment when it needs that intensive specialist care …The data around which types of people take up the most hospital time and services is a difficult thing. People with chronic disease go in and out of hospital taking up a huge amount of resources and that resource then can’t be used for other more straight forward needs.

(Director Royal District Nursing Service, MA2)

Viewing healthcare under an administrative gaze, the supply and demand triggers are identified as professional decision making and patient consumption. MA2 identifies heavy consumption as undesirable and as the cause of inefficiencies. The requirement for data to be used to address patient utilisation behaviour is expressed.

5.3.6 **Summary of the boundaries of administrative authority and practice**

In summary, the rise of administrative practice in the management of hospitals positioned hospital administrators to influence medical professional decision making. The increasing influence of health economic statistics in the governance of healthcare was suggested by the respondents. The problem of healthcare, which had been accepted as a technical issue of managing the right level of affordable services in the 1970’s, was expanded to include managing quality. The application of administrative techniques such as accountability was having a disciplinary affect on the profession and the hospital system more generally. Applying a financial management framework to professional judgement called into question professionalism as a governance mode. Judged by comparison data and accountable to a broadened concept of quality which included the financial implications of resource utilisation, the professions right to speak on quality healthcare was being perceived to be undermined by the respondents. The possibility of statistics and comparison data captured via Casemix to quieten disputes was recognized. Casemix provided the States with a tool to influence hospital administrators to implement the Commonwealths overarching agenda of supporting a transfer to a corporate governance mode. The administrators’ right to speak about the right way to practice the administration of medicine, which was underpinned by Casemix, was perceived as supporting a position of influence over practice.
5.4 The New Position and Role Occupied by Health Economists

The previous section highlighted the impact Casemix had on reshaping professional boundaries, and positioning health administrators in care decisions. This section will look at the conditions which positioned economists in the transformation of the discourse of health. Participants discuss the impact of econometrics on perceptions of quality healthcare and the changing ideas about administration deployed through management practices inscribed in Casemix.

5.4.1 Economists assuming key decision making positions

Victoria’s Casemix implementation has been closely associated with Stephen Duckett the health economist who designed and implemented the system. A former hospital administrator describes his understanding of Stephen Duckett’s involvement:

I don’t think it’s probably any accident of history that Stephen Duckett was at La Trobe University at the time and was keenly involved in this research area … the coffers were pretty bare, there was a higher level of scrutiny across all areas of government activity, those things sometimes just coalesce. Sometimes, not necessarily accidents, but you get the right people in the right place at the right time for those appetites to develop into something that’s delivered.

(CEO Victorian Healthcare Association, MA4)

Describing the constraining impact of budgetary control and accountability measures on State Government activity, MA4 suggests the impact of reforms of the 1980’s and 1990’s in support of the corporate management of the State, in which administrative techniques in the management of healthcare could gain prominence, positioned Stephen Duckett an economist in the right place at the right time. Stephen Duckett had studied economics at the Australian National University and health administration at the University of New South Wales. From 1983 to 1993 he held various roles in the Victorian Health Department, including Director of Acute Health Services. Between 1996 and 2005 he was Professor of Health Policy and Dean of the Faculty of Health Sciences at La Trobe University. MA4 explicitly suggests the legitimacy granted to an economist capable of identifying possible solutions to the problem of healthcare expressed in terms of cost, efficiency
and effectiveness. Implicitly, MA4 suggests that healthcare was being conceived of as an economic issue within broader economic restructuring.

As secretary of the Department of Health and Community Services, Dr John Paterson was also recognized by as actively pursuing Casemix. A former hospital CEO describes his influence as:

There was a highly skilled academic with a view that just cutting costs … the whole idea of understanding if it was operating efficiently ... As I say the time was right and there was someone there willing to take the flack to say ‘I’m just going to do it’.

(Director Health Consultancy agency, former hospital CEO, CR5)

MA3 also suggests the convergence of corporatist aims for cost efficiency and the skills and the knowledge to deploy technical tools for change:

In 1992 Jeff Kennett came in with a huge mandate to do something. He was a great slasher of budgets. He was keen to reduce the health budget. He certainly reduced the number of beds ... Stephen had an enthusiasm for Casemix ... He had quite a senior job by 1992. I don’t know if it was design or chance that someone who could think that way happened to be there when the new government came storming in and wanted to change things.

(CEO General Practice Victoria, MA3)

The desire to reduce budgets is identified as driving the reform agenda. Casemix is recognized as the technical tool for change within this agenda by MA3. The changed way of thinking about healthcare suggested by MA3 as a product that can be conceived of within a financial management framework. Casemix, which identifies products of health services and allows for hospital care to be priced, supports this view of healthcare. Both MA3 and MA4 were questioning of an explanation of serendipity with respect to the availability, knowledge and positioning of Stephen Duckett as a key player in the implementation of Casemix. The elevation of economists to key policy decision making positions during the 1980’s and 1990’s has been noted by a number of researchers. Weller and Wood (1999) describe the change from the Menzies to McMahon governments (1941-1972) when the proportion of departmental secretaries possessing economics degrees was 31 percent, through the Whitlam period (1972-1975) when it rose to 36 percent, increasing to 44 percent in the Hawke and Keating period (1983-1996) and reaching 70 percent for those appointed by the Howard government (1996-2007) (Wellerand, Wood 1999:27, 30). The largest decline between 1965 and 1995 was those holding degrees in
engineering, medicine and law (Fisher 1990:137). By 1993 the Joint Committee of Public Accounts describes 95 percent of the 250 policy advising staff in Treasury as having a degree in economics. Considine and Lewis (1999) found the percentage of influentials - with respect to health policy decisions - with medical qualifications fell from 58 in 1991 and 1992 to 34 in 1993, while economists rose from 11 to 38 per cent. In terms of influencing policy, the concerns of economists were noticeable throughout the late 1980’s and 1990’s. The right to speak about health administration as a financial management issue had been gained by economists.

5.4.2 Existing institutional arrangements constraining change

Bringing about change in healthcare delivery practices to influence resource utilization is difficult as a former hospital administrator explains:

… we do tend to make our hospitals like sacred cows. Once a level of activity and a profile is established around public expectation of service delivery from that agency, it is very difficult to change that: partly because of the medical politics and their capacity to resonate with the community and to scare monger to an extent. Partly too because it is pretty difficult to move away – if you have a strong urology focus - to have a strong orthopaedic focus – there are completely different infrastructure needs around that. With orthopaedic you are going to have some rehab for example, there are different considerations. So, it’s not that easy to change anyway irrespective of the political risks associated with trying to change.

(CEO Victorian Healthcare Association, MA4)

The structures of the profession, the doctor patient relationship, the professions right to speak on how to deliver care, and infrastructure as supporting existing institutional arrangements are described. An understanding that the climate of change being created by a view of healthcare as an economic good was not sufficient to bring about change is suggested. The respondent describes the difficulty in changing social values with respect to the biomedical model and the level of service it supports. Implied is that profession did not share the goals of the government, impacting the ability of the government to introduce change. What is highlighted by the respondent is that the government can only influence and not command change in healthcare, and that the status quo is supported by the existing institutional arrangements.
Supporting the view that a climate for change created by a desire to reduce the health budget would be insufficient to bring about change in healthcare, MA3 suggests the profession would resist:

The medical profession are always quite suspicious of change because they are stuck with the fee-for-service system. That is what they use because that is the system in Australia. If you’re working in that sort of culture and people start talking about change you will think my income is going to go down. The way it is often marketed is ‘yes, and quite right too’, that sort of stupid way that people approach it. It is a silly way to try to get people to agree to change.
(CEO General Practice Victoria, MA3)

The fraught nature of relations between a cost conscious government and the medical profession is described in this response. MA3 highlights that negotiations to gain agreement for change require sensitivity to health as being delivered through privatized businesses. MA3 suggests that change would be perceived as negatively impacting upon the professions working conditions. Explicitly suggesting that a picture of the profession as overpaid and too expensive is painted by reformers, MA3 describes this view as provocative. Implicit in MA3’s response is the taken-for-grantedness of the view of the medical profession as conservative, self-interested and resistant to change.

The professions ability to negotiate for the retention of the status quo was suggested by MA4 and CR5:

Funding models have always changed. This (Casemix) was another change but a more threatening change because people thought it was heading towards a capitation based funding model, though it never quite got there. It still carries with it that historic background today. Really at no stage to my knowledge has any agency necessarily lost a huge chunk from where they started from. Why? The medical fraternity and other players.
(CEO Victorian Healthcare Association, MA4)

My experience at the time was the bigger hospitals had the greatest cultural resistance. So monolithic, so difficult to shift. Some of them found it difficult to persuade the medical staff they could do things differently.
(Director Health Consultancy agency, former hospital CEO, CR5)
The capitation payment system is based on an enrolled primary health population. General practices are paid according to the number of people enrolled not the number of times a provider sees patients. MA4 describes the vulnerability of the profession to government funding models in a universal health insurance scheme. MA4 argues that despite changes to the funding models, real change in how funds are allocated has not eventuated. The weak negotiating position of the government who must gain agreement from the profession for change to be effected is highlighted. The structures of the profession and the professional bodies are seen as complicit in resisting change. The attractiveness of the fee-for-service model to the profession is emphasized.

Activity based funding and the categorization of professional services as products were the policy tools introduced by Casemix. The introduction of competitive structures into professional practice in order to impact on the variation of costs and activity levels between hospitals was described as a failure by MR6 who describes the use of the public power of the hospitals as maintaining the status quo:

The State Government tried to put the hospitals in competition with each other and they tried to privatise some of them. It failed basically. It was a fundamentally flawed. You try to reward the hospitals – so Monash medical center does really well and gets more and more money and Western hospital does really badly and gets less and less money. Suddenly all the people in the Western suburbs can’t get access to hospital care because their hospital’s not performing, well that’s not going to work. They can’t go to Monash. Those ideas have their limits.

(Director Center for Online Health, former Executive Director, Extended Care Centre (MR6)

MR6 argues that competitive ideas incorporating consumer choice are inapplicable in healthcare because patients cannot choose their hospital. By suggesting the inevitability of variation between hospitals, MR6 is implying the variances cannot be managed. Access to technology, people, and patient selection procedures all have the potential to improve the performance of hospitals, requiring time to change. The criticality of continued provision of regional services provides hospitals with their public power. MR6 highlights the ineffectiveness of competition structures in reforming healthcare conceived as a public good.

5.4.3 Supporting a role for economists in creating a climate for change
Casemix was contributing to the idea that introducing efficiency measures was ‘the right thing to do’. Perceptions of econometrics as positive fact were giving confidence to economic descriptions of the right way to practice. A former hospital CEO describes the experience in practice:

My sense was that the system was giving the right answers, that Casemix was giving the right answers. I had nurses say to me ‘people are going to die because of you’ and I’d say ‘well, I don’t think so’. We’ve just got to fix it. We’ve got to make it work properly. Nurses were highly resistant. The younger ones were saying ‘… we know there is waste here, they’ve caught up with us let’s get on with it’. There were those that were highly resistant and those that embraced it. Those that said ‘if we’re way out of line with our peers let’s look at it and fix it’.

(Director Health Consultancy agency, former hospital CEO, CR5)

Described is the ability of Casemix data to depoliticize arguments of care and social equity through the use of comparison performance data, to focus attention on the problem of healthcare understood as resource utilization. Indicating the confidence he felt to challenge medical professional risk assessments, CR5 highlights the value placed in Casemix data to make practice decisions.

With limited capacity to change funding allocations, the deployment of the Casemix funding mechanism was interpreted as a disciplinary instrument ensuring accountability to corporatist competitive structures by one former hospital administrator:

The thing that started to happen was with the data entry around clinical categories across all of the different diagnostic related groups that came with Casemix. … It was just an implied responsibility around working within your budget. We’ll keep away if you work within your budget, if you don’t work within your budget we might get someone else to do the job to make sure you actually deliver. Before under block funding this is what it is, if you go over let’s have a chat at the end of the year and find a pot of money for you. That was a fundamental change as to how the budget was viewed right from the outset.

(CEO Victorian Healthcare Association, MA4)

MA4 describes the government’s reforms as steering from a distance the delivery of health services within budget through the use of Casemix. MA4 highlights the tactic of offering practice autonomy in return for applying the concept of healthcare as financially manageable. The scrutiny afforded by Casemix which could occur from outside the professional boundaries
was influencing changed behavior. MA4 suggests political will to change from professionalism as the governance mode to corporatism existed.

This point is further emphasised by MA3 who explained that Casemix made escape from scrutiny difficult, despite the powerful position of large hospitals:

> One of the problems with very large hospitals is the department has a great deal of difficulty making them do things. If they have some measure like Casemix which is the actual measure that is used, as skilful as hospital managers are at getting around things there is something the department has got.
> (CEO General Practice Victoria, MA3)

Casemix deployed as a standardized output measuring tool was capable of enforcing compliance. MA3 argues that Casemix as an output metric was a control mechanism. The suggestion that Casemix gave the government a means for determining the direction of healthcare is implied.

### 5.4.4 Changing Practice

An interpretation of the management objective of accountability as acting on the practice of medicine, influencing the decision to admit patients was suggested by MA2:

> You also put that pressure down onto the doctors and nurses running it. The doctors and nurses make decisions about how many staff they will have on, how many beds they will have open because they know how much budget they’ve got, how much they are funded for, they make decisions around availability of service based on what they will get because they are running a business.
> (Director, Royal District Nursing Service, MA2)

Conceptualizing healthcare as a financial management issue has changed the practice behavior of the profession, subjecting professional decision making to a corporatist control mechanism. MA2 highlights that practitioners were subject to accountability practices which encouraged behavior attuned to the market mechanisms of supply and demand, behavior which was competitive. Implicit in MA2’s response is an understanding that the concept of healthcare as a product allows groups outside the professional boundary a voice in the right way to deliver healthcare services.
Changed governance structure legislated for under the Health Services Act (1988) described the election and appointment of health service boards of directors in Victoria. Board members with specific expertise in areas such as finance, investment, law, human resources, marketing or public sector administration were sought (Victorian Department of Health and Community Services, 1988). SECT 65T (3) (a) of The Health Services Act (1988) specifies that ‘the board of a public health service shall include at least one person who is able to reflect the perspectives of users of health services: and the Minister must give preference to a person who is not a registered provider within the meaning of the Health Services (Conciliation and Review) Act 1987: and who is not currently or has not recently been employed or engaged in the provision of health services’. The Health Services Act (1988) within Victoria is very specific in relation to the powers of the Minister which includes the ultimate power to dismiss the Board and to appoint in their place an administrator. This has changed the behaviour of the boards to become more responsive to Government as a former hospital CEO explains:

Over a period of time you’ve ended up with paid boards, bigger networks, appointed by governments. Pretty much doing the bidding of Government to a large degree … they are far more a creature of the Government than they were in the past…. I think on the whole Casemix funding issue, it was about reducing the capacity for embarrassment politically. It was their increasing capacity to influence the way hospitals were run internally. … It was a very centralist control perspective.

(Director Health Consultancy agency, former hospital CEO, CR5)

Described are the formal legal powers and resources of legitimacy and authority relied on to manage the involvement of the board in the policy process. The appointment of board members with an economic perspective facilitated a political exchange, Casemix provided support for the Governments claim to being able to manage healthcare within budget. Casemix’s role in support of reform is understood as allowing the Government to steer from a distance practice change, and providing authority to speak about, and act, on the right way to practice.
5.4.5 Summary of the role and position of economists

In summary, a concept of healthcare as a product was perceived as subject to a profession reluctant to accept corporatist control mechanisms. The participants’ responses suggest the elevation of economists to decision-making positions in healthcare marked the introduction of ideas about administration deployed through management practices inscribed in Casemix. The problem of bringing about change in practice was interpreted as professional behavior. The possibility of Casemix to make the professional accountable for their behaviour to an audience interested in corporate competitive structures was recognized. The professions right to speak about the right way to practice the administration of medicine was being undermined through accountability practices diffused through Casemix.

5.5 A New Mode of Functioning of Language

The previous section highlighted the impact of the elevated position of economists, and subsequently administrative technique, on devolving authority to speak about the right way to practice healthcare. This section will focus on the way in which efficiency metrics reshaped perceptions of equitable access influencing the way the role of Government was understood. Participants describe a changing view of the problem of delivering healthcare to wards a technical issue of applying competitive structures to manage cost and quality.

5.5.1 Creating an understanding of how the health system was performing

The economic cost of health within the broader microeconomic reform agenda replaced social justice concerns as an influencer on decision making, described here by CR5 and MA4:

…that was part of the transformation to say that kind of social admission had to stop – people going on holidays for a couple of weeks and whacking grandma in hospital – it was a completely inappropriate use of public funds and facilities but that was common place. That’s not an acute care role. That was part of the change.
(Director Health Consultancy agency, former hospital CEO, CR5)
I can only presume that the impetus was around technical efficiency and wanting to have a more direct relationship between activity that was going on and how much treasury was allocating to that activity. Prior to Casemix it was quite difficult to gain any true understanding of that. We would have still had data – bed day data, patient discharge data – but you would have had great variances in length of stay from one agency to the next. It was hard to understand what the data actually represented.
(CEO Victorian Healthcare Association, MA4).

MA4 describes the inadequacy of data structures which supported professional institutional arrangements to application within corporate administrative techniques. MA4 identified the need for data structures which supported a view of health as a financial management issue as the impetus behind the deployment of Casemix. MA4 expresses an unambiguous understanding of efficiency as a natural outcome of reforms involving Casemix. MA4 explicitly recognized the possibility of information systems to limit interpretation of the problems, and solutions to healthcare. Implicit in the response is an understanding that scrutiny was avoided through control of information flows.

Presenting an objective measure that could be interpreted as the true nature of how the health system was performing was understood as the decision for output based funding:

I think they wanted to reduce the budget. That was probably the most important thing. Conservatives would find a nice objective measurement quite convenient. People say it was Stockdale that was running the government really, the treasurer. … He was certainly the driving force behind their economic approach.
(CEO General Practice Victoria, MA3)

Metrics as useful tools in depolitising decisions to reduce health budgets is described. MA3 suggests the utility of metrics perceived to be neutral in framing the problem of healthcare as cost.

5.5.2 Quietening opposition

Casemix as a means of depolitising funding decisions was suggested as strengthening the position of the State governments in negotiations with hospitals:
Budgets were being set on the back of negotiations with individuals and history, so the premise behind Casemix was that it would be a more transparent and equitable distribution of funds. I’m not sure that it has achieved that, in essence because the history still was very strong. … funding had become a benefit of how good a negotiator you were. So if you were a really strident negotiator and effective in your stridency then you might have been able to negotiate a much better outcome relative to hospital A, who might have had leadership skills that weren’t as strong in that negotiation area but might have been strong in a different area. But because they’re at the negotiating table at the same time they may not have got the same outcome.

(CEO Victorian Healthcare Association, MA4).

A change to the concept of equity in healthcare from equitable access to health services to equitable access to funds is identified. MA4 describes the process for allocating funds during the period when healthcare was considered a social good as involving professional concepts of trusted relationships. The process of allocating funds under a concept of health as an economic good introduced corporate concepts of performance metrics and accountability. Explicitly, MA4 describes the neutrality of Casemix as doing little to depoliticize funding decisions. Implicitly, MA4 suggests hospital funding is a political process.

A concept of equitable access to funds as the accepted definition of equity was also suggested by a former hospital CEO, and a former director of an extended care facility:

I was at a hospital that was cutting. There were others where it was said ‘you’ve been getting a pretty raw deal here’ so you’ll end up getting more because you’ve been under funded. The facilities were run down or what ever. They ended up with more. So, people could see this was about equity not just about cutting.

(Director Health Consultancy agency, former hospital CEO, CR5)

He (John Paterson) had this view that everyone was always lobbying for more money, there was constant noise, and you don’t really know how much is enough. ... They were trying to stop this argy bargy between hospitals about we are trying to get more money because we get all the people with one leg which was going on all the time. So, they saw an opportunity to provide equity of funding. The tool set became available. ... It didn’t stop that debate, it changed the context of the debate. There were endless discussions about what equity is. This was an equal pay for equal work kind of idea.

(Director Center for Online Health, former Executive Director, Extended Care Centre (MR6)
Describing the demonstrations of equity as fairer funding decisions, CR5 an MR6 suggest protest over the Governments role in reducing funding was quelled. As a means of distancing context and history from administrative decisions, Casemix was employed in depolitising the impact of political decisions. A former hospital administrator expands:

One of the initial things was around competition. Shutting down a hospital is never an easy political thing to do. So if you change the funding formulae in such a way that it becomes bleeding obvious to the people running it that they can’t sustain their business under the funding formulae then you are almost forcing a decision to be made.
(CEO Victorian Healthcare Association, MA4).

Quietening opposition to politically sensitive decisions is the suggested intention of Casemix metrics which support a seemingly unambiguous understanding of technical efficiency. Highlighting the use of budgetary control to influence compliance with State government objectives, MA4 suggests the use of administrators to implement the difficult political decisions of reducing funding to healthcare. The respondent is suggesting an output based funding model was introduced to change perceptions about what could be sustained in a corporate competitive environment. Implicitly MA4 suggests political decisions became administrative decisions via Casemix and were implemented by autonomous administrators.

The view of healthcare as a problem of financial management, and competitive comparison measures, was limiting debate on political decisions making:

I’m not sure that the government technically closed any hospitals. The government would always say that technically it was a decision of the board, but those decisions reflect the funding policy of the government which becomes unsustainable for that board to stay in business. It is a play on words. It is just an unfortunate reality and I guess within that context we’d have to say ‘well if that board was making that judgement that they couldn’t sustain activity under that funding policy but 98% is sustaining activity under that funding policy well then maybe there is a good argument for why those places closed.
(CEO Victorian Healthcare Association, MA4).

Describing the impact of budgetary controls and comparison data, MA4 and CR5 suggest that the implementation of government policy was steered from a distance. MA4 emphasized the decision to close hospitals was considered to make sense, to be irrefutably the right thing to do,
within a competitive framework of financial management. MA4 suggests protest was quietened by comparison data between hospitals and an understanding of variances as reflecting inappropriate or inadequate performance within competitive structures. Explicitly, MA4 and CR5 express the view that politically sensitive decisions concerning removal of health services were made by the government who applied administrative disciplinary tools to implement these decisions in practice. Implicitly, MA4 and CR5 highlight an acceptance that administrative disciplinary technologies such as reimbursement systems, allocation of resources and pricing and a belief in rational behavior were important factors in a concept of healthcare as an economic good.

5.5.3 Unintended Behaviour

Healthcare as a competitive economic good accountable to quantitative performance measure of productive activity was difficult to steer from a distance. MR6, MA3, MA4 and CR5 described the impact in practice. MA4 specifically states:

If we look at rural Victoria and also in the metropolitan area – one of the underlying premises of introducing it was competition. So to create competition among hospitals, here is the price if you can deliver more services for that price well then that’s what we’re interested in, and then that created a whole lot of outcomes as well.  
(CEO Victorian Healthcare Association, MA4).

Describing the market mechanisms being introduced into healthcare, MA4 explains that hospitals were encouraged to do more for less in order to attract funding. Incentives to increase throughput were introduced to offset anticipated longer waiting lists as budgets were reduced. MA4 is suggesting that the practices which lead to doing more for less under competitive structures led to less than optimum outcomes. A former director of an extended care facility describes the outcome in practice:

In the first year the hospitals saw it as an opportunity, they said ‘oh, if we do more work we’ll get more pay’. Before that it was all historical budgets so there were no incentives to work. In the first six months, there was accelerated activity in hospitals as people pumped through work. Then of course it started to break the health budget. Within a year they were capping the activity of every hospital, which was not how it started. ... the idea was to get hospitals more productive, or the cost per episode to come down.
Describing the activities of hospitals as driven by financial incentives, MR6 suggests the crudeness of efficiency metrics as the basis for funding decisions in a publicly funded system. The idea that provision of health services could be made profitable is described. Introducing competition without the profit motive of a market place required the system to be renegotiated in order to constrain profit seeking behaviour.

As a technical issue of resource utilisation decisions about practice were detached from notions of equitable access with some unintended consequences. CR5 describes:

> The numbers were important. There is no two ways about that and analysis and understanding of things and product lines for want of a better word and so on. There was a lot of discussion on that – saying we’re losing on procedures X so we won’t do it any more. You don’t hear it as much these days but there was a discussion of ‘well, we’ll get rid of that particular thing, the weights are wrong’. But, that was the kind of thing we were anticipating. People were put in to review the cost weights.

(Director Health Consultancy agency, former hospital CEO, CR5)

Health as an economic good drew attention to the economic attractiveness of specialising in practices which would, through efficiency measures, provide the greatest return on investment. The support which Casemix provided to a concept of the hospital as a factory production line is emphasized in this response. Awareness of the procedures which attracted funding was driving decision making in relation to treatment offered, requiring the system to be adjusted.

5.5.4 Unintended consequences for smaller hospitals

Smaller hospitals with fixed overheads struggled to offset efficiency targets with increased throughputs. CR5 describes the constraints:

> … the smaller hospitals had the issue about occupancy and variability in occupancy. That was very difficult to manage compared to a large metro hospital which had high occupancy and very predictable throughput, to resource that with a reasonable degree of certainty. Whereas with a small hospital they’ve got permanent staff that makes it
difficult under a Casemix system. On the counter side they had a great capacity to engage their staff, to change and be flexible.

(Director Health Consultancy agency, former hospital CEO, CR5)

A consequence of the policy was the centralisation of activities and specialisation of service in order to take advantage of efficiencies in process, favouring metropolitan areas, as MA4 explains:

If you look at maternity, and you look at Monash Medical Centre and Mercy Women’s you probably have the lion’s share of the maternity activity in the state. If you include Barwon you cover off a huge portion of the state, and the analysis of cost weights associated with the provision of maternity services and therefore price.

(CEO Victorian Healthcare Association, MA4)

Cost weights in Victoria were developed from hospitals with computer-based costing systems. Initially, this involved only five metropolitan hospitals (Phelan, Tate, Webster, Marshall, 1998). Coded individual patient data identified variations and outliers, and cost weights changed over time as gradually reducing length of stay, increases in day surgery and changes in clinical management practice (e.g., use of different drugs, operative procedures or prostheses) changed (Phelan, Tate, Webster, 1998). To allocate a cost weight to each DRG a Benchmark is established.

For example an appendix DRG may have an average cost of treatment of (say) $1,000.00. This might be chosen as the Benchmark and allocated a cost weight of 1.0000 (decimal places are important). Then in comparison to the cost of a heart transplant at say $40,000.00 the heart transplant will have a cost weight of 40.0000. If removal of a bunion costs $100.00 then the bunion has a cost weight of 0.1000. To determine the amount of money that a Hospital is to receive for the DRG, the Benchmark Price is applied (T.C. Health Administration, 2001:4).

The benchmark system introduced continual improvement goals aimed at doing more with less, which have driven a system driven to constrain resource usage. CR5 suggests it has prevented new approaches to practice being introduced into the system:

Part of Casemix is that it is a ratcheting down system. When you improve your performance it become the base for next year, when you improve again it becomes the base for the following year. So the system was made more efficient or ratcheted down,
depending on how you want to see it. That means it runs in a certain way and people run around and do things in a certain way and they get paid a certain amount. To change all of that means somebody with the time to sit back and time to invest in changing it.

(Director Health Consultancy agency, former hospital CEO, CR5)

MR6 also described the constant pressure of productivity targets on the decision making of administrators:

The administrators became very preoccupied with activity and income streams and hitting the target exactly. The art form was not to go over your target or you’d be doing work you weren’t paid for. So there was this kind of whole culture developed of trying to deliver the right amount of output at the lowest possible price. The tension you had was you had to deliver a certain amount of admissions if you like, you had to do that with as little resources as you could, you had to contend with a 1.5% productivity improvement every year and that was the life of a senior operations CEO. That was your currency in thinking about your day to day work.

(Director Center for Online Health, former Executive Director, Extended Care Centre, MR6)

MR6 describe the value placed in competitive targets in the decision making of administrators. A view of a good administrator as someone who could manage within the targets, someone who could pull it all off was conceived. The value placed in the performative worth of the administrator was their ability to do more with less. MR6 suggests that striving to meet the targets was viewed as the right thing to do, limiting opportunities to resist.

The pressures faced by smaller hospitals were described by a former director of an extended care facility (MR6) as their inability to present themselves as efficient:

Of course Casemix doesn’t work in small institutions. The smaller the cohort the less reliable it is. It works better on bigger populations. It doesn’t explain all the costs. You can’t really run small places precisely on Casemix funding like you can bigger places. You’ve got to provide some underpinning budget so they survive. The rationalising of hospitals – they obviously looked like they were high cost per unit of service delivery – they do look inefficient.

(Director Center for Online Health, former Executive Director, Extended Care Centre, MR6)

Valued for their ability to do more with less, smaller hospitals were not competitive with their larger counterparts. MA4 describes the problem smaller rural hospitals experienced when
constrained by budgets derived from benchmarks established by hospitals capable of creating economies of scale through specialization and centralization.

The example we constantly give is if you look at Swan Hill which has about 260 births a year, Barnsdale which has about 340 births a year, the infrastructure and fixed costs associated with maintaining maternity in those two regional centres is going to be very much the same. There will be a slight variable, they won’t have an obstetrician employed, they will have a specialist obstetrician who they pay on the basis of visits. Fundamentally most of their costs will be fixed. The activity based model doesn’t actually fit that, and then you can get further flung rural areas which have to delivery maternity services but only have 80 births a year, but due to rural sustainability issues and equity of access issues it is important that that particular town has to have maternity services available. (CEO Victorian Healthcare Association, MA4).

Obtained by the researcher under the Freedom of Information Act 1982, the document ‘Costing the Australian Hospitals with 15 to 50 Beds, prepared by KPMG Peat Marwick for the Commonwealth Department of Health, Housing and Community Services (1992), describes the ‘strong support for a costing project aimed specifically at smaller hospitals’. Among the objectives were ‘develop and validate AN-DRG relative cost weights for smaller hospitals by applying the methodology developed as part of the national DRG costing study and compare the derived cost weights to those developed for larger hospitals’ (pg 1). The use of national costing data as a standard is reflected in the comment ‘our preference is to make minimal changes to the manual (Study Hospital Costing Manual) (thereby enhancing its status as a standard)’ (pg 6). The standard set by the Commonwealth would be used in benchmarking the efficiency of hospitals – and the efficiency of State management. The selection of the benchmark metric represents the disciplinary potential of Casemix.

Casemix funding based on benchmark metrics as a competitive structure which supported the institutional arrangements favoring large hospitals was described by MR6, MA4 and CR5. The ideas of equitable access which had underpinned the notion of healthcare as a social good were replaced by equitable access to funds which underpinned the notion of healthcare as an economic good. The metrics which subjected smaller hospitals to levels of activities achievable by large hospitals called into question their sustainability. Closures and amalgamations of smaller rural hospitals became the ‘right thing to do’ and were a feature of the deployment of Casemix
between 1993 and 1996 (Mangaro, 2001). Implicitly, MA4 and CR5 suggest the application of administrative disciplinary techniques as presenting smaller hospitals as inappropriate when viewed under a competitive financial management framework.

5.5.5 Unintended consequences for lasting practice change

Suggesting an unintended consequence of Casemix as the position afforded large hospitals to resist a transfer of power, MA3 suggests hospital administrators of large hospitals could avoid the gaze of administrative techniques:

In the Kennett era when there was a craze for big hospitals, the hospital managers realised they could do better by negotiating unilaterally with the department of the government.
(CEO Victorian Healthcare Association, MA3).

The response describes the professions ability to maintain the status quo. MA3 suggests the strength gained by large hospitals to resist a transfer of power. Highlighting that the constraints imposed by corporate control mechanisms were considered undesirable by the hospitals, MA3 identifies self interest as the motivation for resistance. Implicit in the reply is the autonomy of large hospitals was supported, and that a renegotiation of the system occurred to avoid the disciplinary impact of administrative techniques.

Also arguing the status quo had been maintained is CR5 who states:

I don’t think it has made the system efficient. I think the hospital system is monumentally inefficient. But no one has actually invested in process change or process redesign to the degree that I think they could and should.
(Director Health Consultancy agency, former hospital CEO, CR5)

Yong and Harris (1999) and repeated by Mangaro (2007), applied stochastic frontier estimation of a production function to panel data for the period 92/93 to 95/96 in order to establish whether efficiency improvements in Victorian hospitals had been realized. The results showed no significant change to individual hospital efficiency levels as a result of the introduction of
casemix IS. Cost savings were concluded to be a direct result of closures and amalgamations that occurred in regional Victoria (Yong and Harris 1999, Mangaro 2007). The ability to avoid practice change by increasing throughput and specializing in services with the most attractive weights, combined with a powerful negotiating position, has allowed the large hospitals to avoid real reform.

Conceptualized as an output based economic good, healthcare funding decisions made on the basis of efficiency metrics, and value for money, constrained debate about the appropriateness of the approach, e.g. MA4 notes:

The unfortunate thing was that in rural Victoria there were a couple of casualties in the early times. It was only probably 6 or 7 years into Casemix that they moved away from activity based funding for the smallest agencies and went back to block funding in recognition that activity based funding didn’t suit them because of the nuances of activity. They have just such small numbers of each throughput group that it is impossible to achieve the same efficiencies as someone who has ten times that activity. That recognition came about around 2000 or so. It would have been the change of government.

(CEO Victorian Healthcare Association, MA4).

The renegotiation of the system reflected a renegotiation of the concept of equity from its narrow conceptualisation as access to funding to the previously accepted understanding of access to services. Suggesting that the reversal was a political and not an administrative decision, MA4 associates the change in understanding of healthcare with a change in government. Implicit in MA4’s response is an understanding that the Government’s responsibility for funding healthcare had obscured its responsibility for equitable access. Casemix remained in use with accountability, metrics, and comparisons core elements in the corporate control of healthcare. The renegotiation resulted in the profession being made answerable to, rather than accountable for, output performance metrics.

5.5.6 The renegotiated system

Economic measures and Casemix has become a contested site. Economic metrics describe increased levels of hospital activity at reduced costs fulfilling the aims of value for money. The upsurge in same-day medical cases in Victoria was investigated by the Victoria Health
Department in 2002. Following an analysis of the Casemix data they concluded that much of the growth was due to administrative/definitional changes rather than clinical treatment changes (Department of Human Services 2002:34). The clinical codes used in diagnostics make it difficult for people without medical training to challenge the treatment offered. Various explanations for performance change were possible, as MA4 explains:

If you look at the jurisdictions which didn’t have Casemix, they reduced their length of stay during the same period of time. I think it was really more reflective of practice and new technologies and new pharmacology’s’ … but other jurisdictions also had reduced length of stay that weren’t using Casemix – they just must have used different tools. As I say the technologies and everything that have changed in that same timeframe have also been significant contributors in the absence of any other tool. It is simply a matter of manifestation of improved understanding of technologies around the way in which we deliver services. The keyhole surgery, for example, was only – or might not have even been known of – 17 or 18 years ago. Endoscopic surgery was only just starting. Day procedures weren’t the norm, now they are the norm because of those technologies. (CEO Victorian Healthcare Association, MA4).

MA4 is suggesting that despite introducing coding of medical practice, interpretation of medical practice remained in the control of the profession. Explanations of efficiency gains attributable to the administrative techniques used by Casemix to make the profession accountable to competitive structures can be challenged. Casemix data which provided the information for reporting purposes used to assess efficiency, required diagnostic and treatment information provided by the medical profession, constraining explanations of causation.

Questioning the legitimacy afforded explanations of efficiency garnered from Casemix has enabled a redefinition of the boundaries controlled by administrative techniques such as economic metrics:

We’re 17 or 18 years in now and a lot of that notional element has changed. A lot of how people now view Casemix is as an expression of technical efficiency, not distributive or allocative efficiency. That’s a positive thing to some extent, but it’s also still a pricing tool. (CEO Victorian Healthcare Association, MA4).

MA4 suggests that a broad unambiguous definition of efficiency was contested, restricting how the Casemix information could be interpreted. MA4 describes the restricted boundaries in which
economic metrics and administrative techniques could operate in a constrained definition of efficiency. Technical efficiency refers to the physical relation between resources (capital and labour) and health outcome and addresses the issue of using given resources to maximum advantage (Palmer and Torgerson, 1999). The concept of allocative efficiency describes the efficiency with which health outcomes are distributed among the community. Faced with limited resources, the concept of allocative efficiency will eliminate some technically efficient resource allocations (Palmer and Torgerson, 1999). As MA4 notes:

The push back was more around the allocative efficiency aspect of it and what the implications of it might be in rural Victoria in particular, but also in some metropolitan areas. … How do you deal with that in terms of slicing up the cake available? (CEO Victorian Healthcare Association, MA4).

The respondent describes the inability of the government to disseminate an interpretation of efficiency measures captured through Casemix in broad unambiguous terms. Administrative decision-making could not be distanced from context and history. MA4 is describing a continued role of Government in ensuring equitable access to healthcare services, a role which was obscured by the Governments financial responsibility for funding healthcare. Restricted to interpretations of technical efficiency, the disciplinary impact of economic metrics and Casemix was being renegotiated to make the profession answerable to, not accountable for, performance measures.

Presenting Casemix as a tool involved in technical efficiency the role of responsibly funding healthcare is described as a routine task or paying for services, and not directing the outcomes of healthcare. A doctor manager (MR6) who was director of an extended care facility describes:

You are paying for events of some sort, some of which have a health benefit. You aren’t really paying for community health directly, you pay for people to do stuff, either get people in or out or do a procedures. To the extent that those events improve the health of the community, it is relevant but it’s not really as direct as all of that. Casemix in hospitals is a type of artefact something that creates perverse incentives in the rest of the system. It creates its own internal reality in the hospital. (Director Center for Online Health, former Executive Director, Extended Care Centre (MR6)
The respondent is suggesting broad acceptance of technical efficiency reflects Casemix as a thing, the interpretation of concepts embedded in allocative and distributive efficiency in which Casemix is given significance beyond the rational object is localized. The respondent suggests that Casemix’s involvement in technical efficiency is separable from the significance attached to it. The ability of Casemix to rationally allocate resources is presented as predictable and necessary, the ability of Casemix to facilitate a political exchange by changing the value placed in professional decision making within hospitals is unpredictable.

5.5.7 Summary of health as a product subject to efficiency metrics

In summary, the participants’ responses suggest the increasing influence of health economic statistics in the governance of healthcare. The desire to use the neutrality of Casemix and its perceived objectivity as a means of distancing administrative decisions from context and history is suggested. The problems of delivering healthcare were simplified in a view of healthcare as a technical issue of applying competitive structures to manage cost and quality. Assuming an unambiguous notion of efficiency reform debate on the appropriateness of applying competitive structures to the delivery of social goods was limited.

The application of administrative techniques such as accountability was having a disciplinary affect on the profession and the hospital system more generally. However, the professions ability to maintain the status quo was emphasized, strategies for resisting a transfer of power from professionalism to corporatism included contesting explanations of efficient and quality care defined by metrics underpinning Casemix. The renegotiations included the continued use of Casemix, supporting a view that the quantification of evidence about cost and efficiency are necessary for the management of healthcare and for supporting competitive structures.
5.6 A New Form of Localization and Circulation of Discourse

A change in funding mechanism did not necessarily align goals. MA4 states:

Hospital administration was simply at the will of government in terms of their funding policy. When the government decides to change its funding policy you just have to adapt to it, you don’t have any choice in it. I mean there is no rejecting it.

(CEO Victorian Healthcare Association, MA4).

MA4 describes the tolerance of, rather than acceptance of, funding policies by hospital administrators. Explicitly stated is that hospitals must change to work within the new funding conditions. MA4 describes the hospitals as dependent on Government funding and susceptible to coercion by budget control. Implicitly, MA4 suggests that changes to funding arrangements will be fraught: there is no uniformity between the aims of hospital administrators and the aims of the government.

Casemix as systemized information records patient data, categorizes data according to diagnosis and procedure undertaken, aggregates this data with financial data about resource use, and disseminates to allow for differentiation between high and low cost care. Resource allocation, funding, reimbursement, and staffing assignment depended upon the results of the Casemix and volume data. The systemization of information involves the act of coding data, MA4 explains this change:

… The reporting really didn’t change that much I’d have to say. It would have changed in style, but there was still a monthly report that was furnished to the bureaucracy. The thing that started to happen was with the data entry around clinical categories across all of the different diagnostic related groups - that came with Casemix. It was there before it came with coding but not used in the same mechanism – those two things were tied up.

(CEO Victorian Healthcare Association, MA4)

MA4 is highlighting that Casemix uses clinical descriptions to determine the level of resource that a case can attract. The expert knowledge of the clinician determines the right diagnosis and treatment, and determines the category used for coding in order to attract a level of funding. MA4 is suggesting that the act of coding shapes understandings of medical practice as codifiable and standardized, it subjects professional decision making to administrative technique. A
consequence of this is that behaviour which seeks to maximize funding in a competitive environment is made possible as hospital administrators adapt to reduced budgets. In Victoria, if hospitals exceeded their throughput target, they received additional funding at a marginal price (Duckett, 1998). The ability to construct a picture of hospital efficiency and responsibly funding healthcare was desired by the Government, and required professional cooperation. A mutually interdependent relationship between the profession and the government is suggested, securing the medical professional a pivotal role in health information collection and dissemination.

The methodology for analyzing data changed with Casemix, utilizing the lens of economic metrics, MA4 further notes:

We were collecting data around average occupancy to different professional groups and all sorts of things prior to Casemix. I guess this was a simplification in some ways because it was a single expression of cost as opposed to a more detailed analysis of the inputs to achieving those outcomes. It was a purer approach.

(CEO Victorian Healthcare Association, MA4)

Describing the shifting focus of data analysis from understanding healthcare in terms of professionalism to understanding healthcare in terms of corporatism, MA4 highlights the role of Casemix in this migration. Explicitly MA4 describes the population based view of healthcare that Casemix supported. MA4 suggests that the methodology for analyzing population based data which involved viewing data through the lens of economic measures removed ambiguities and vagaries in understanding the problem of healthcare. Implicitly MA4 suggests a view of healthcare as an individual professional service clouded understandings of the problem healthcare, while analysis of Casemix data offered a practical approach for action.

Since its implementation in Victoria, Casemix has been implemented in other states. By 1998 five States were implementing Casemix funding: they all adopted a common nomenclature: all States use a version of Australian national diagnosis-related groups (AN-DRGs) (Duckett 1998, DoHA 2010). Recognizing the mutually interdependent relationships in healthcare, the AN-DRG is produced by the Department of Health and Ageing, in consultation with the Clinical Casemix Committee of Australia, Clinical Classification and Coding Groups, the University of Wollongong (UoW), State and Territory health authorities, and other organizations (DoHA, 2010). All States have introduced coding audits to ensure accuracy of recording diagnosis to
DRG groups (Duckett 1998, DoHA 2010). In all but the smallest remote hospitals, medical records are transferred into computer readable form for reporting (Diers, Pelletier, 2001). Summaries of Casemix data are regularly and publicly reported: The Department of Health Annual Report is tabled in Parliament in accordance with the provisions of the Financial Management Act 1994.

5.6.1 Summary – performance metrics and reporting

In summary, the ability to produce administrative data to provide evidence of the manageability of healthcare has been the legacy of Casemix. Providing the infrastructure to support information creation has increased the dissemination sites for information which informs Government and patients’ views on patient care as a technical issue of managing cost and quality. Widespread use of a standard nomenclatures produced by the Commonwealth Government confirms it a role in setting the direction of healthcare from a distance, while acknowledging the professions right to make diagnosis and treatment decisions. The scrutiny of professional decision making by audiences supporting competitive structures has been reinforced by the methodological foundations for analysis which are applied to population based administrative data. The idea of information as tied to quality through efficiency and resource allocation underpinned Casemix in supporting a view of the problem of healthcare as a technical issue of applying competitive structures to manage cost and quality.

5.7 Summary - The Discursive Formation of Healthcare in the 1990’s

The ‘objects, operations, concepts and theoretical options’ (Foucault, 1979:56) of the discourse of healthcare at the moment in time that Casemix was being introduced, making it possible for transformation in the discourse of healthcare to occur, has been examined in the discussion above. An analysis of the transformations of the discursive formation of healthcare, the change environment for action, has involved identifying the boundaries of administrative practice, the changing role of those who can speak about administration, the new way in which healthcare is conceptualized as a financial management issue and the changed way in which explanations of the problems of healthcare are disseminated.
The competitive structures of the market, accountability measures which included resource utilisation in measures of quality, and evidence in the form of quantitative data combined to form a climate for change. The ability to determine the right level and right quality of services in a system which provided private businesses access to public funds had remained within the boundaries of the profession following renegotiations in the 1970’s, that this needed to change was at the core of reform in the 1990’s. The rise of administrative practice in the management of hospitals which was supported by the increasing influence of health economic statistics in the governance of healthcare positioned hospital administrators to influence medical professional decision making. The problem of healthcare conceived as a technical issue of managing the right level of quality and cost allowed for the use of administrative disciplinary techniques to subject professional decision making to judgment. Judged by comparison data and accountable to a broadened concept of quality which included the financial implications of resource utilisation, an environment in which the current explanations of quality healthcare could be questioned was created. Opportunities for alternate solutions to healthcare in which corporatist control methods were considered appropriate were supported by a view of quality healthcare as inadequate. Government’s attempts to manage the delivery of health services from a distance through the use of efficiency performance metrics and a conception of healthcare as a product obscured its responsibility to provide equitable access to healthcare services. Casemix and explanations of efficiency became a contested site. The broad conceptualization of quality healthcare being proposed which incorporated an unambiguous definition of efficiency did not diffuse. Instead, the idea of information as tied to quality through efficiency and resource allocation was shaped by metrics of quality which included technical efficiency. The position of the profession as pivotal in supplying information necessary to provide explanations of healthcare as a responsibly managed service was confirmed. The renegotiated system made the profession answerable to, though not accountable for, explanations of efficiency garnered through the administrative techniques supported by Casemix. Simultaneously applying a financial management framework to professional judgement called into question professionalism as a governance mode.

Casemix provided the States with a tool to influence hospital administrators to implement the Commonwealths overarching agenda of supporting a transfer to a corporate governance mode.
The continued use of Casemix supports a view that the quantification of evidence about cost and efficiency are necessary for the management of healthcare and for supporting competitive structures. The scrutiny of professional decision making and professionalism as a governance mode by audiences supporting competitive structures has been reinforced by the methodological foundations for analysis which are applied to population based administrative data provided by Casemix. The corporate control mechanisms in the form of administrative techniques of coding, reporting, comparing sought to influence doctors to view themselves as public servants and healthcare as a population based product subject to the same scrutiny as other public services. These ideas did not diffuse into practice, however, professionalisms grasp over healthcare was loosened.

5.8 The Content of Change - The Lasting Impact of Reform Attempts

The role of government in a market society changed to become an economic manager and not a provider of services. A continuing requirement to responsibly fund a universally accessible public health service, while pursuing a policy of distancing itself from service provision, has driven government policies that have created an opportunity for the private sector to draw on public funds via Medicare. Accountable for ensuring ‘value for money’ in a fee-for-service model, the government can influence but not control the impact of reform.

The idea that health was a manageable service, which could be improved by applying supply and demand levers which was being formulated in the health economics discourse of the 1970’s assumed prominence in the 1990’s. During the 1970’s the idea that healthcare was manageable was diffused within a concept of healthcare as a technical issue of managing the right level of affordable services, while control of the supply and demand levers remained outside government control. Health economics as an area of expert knowledge was again being claimed by the Commonwealth in the 1990’s through its investment and direction in the research activities and its access to information and experts, enabling the construction of an explanation for the medical practice as inefficient based on ‘evidence’. The diffusion of ideas through practice can take time. Ideas formulated in the 1920’s and 1940’s, implicated in the practice of categorizing disease, and supported through the systematization of information, formulated ideas about information that it is out there, collectable and transferable. Positioning the doctor into a pivotal
role in the collection of health information was further entrenched in the 1970’s, when concepts of professional ethics tied to maintaining confidentiality were reinforced. It was this conception of the ethical professional which constrained explanations of illness beyond the biomedical model, controlling the means to access research funds in the early 1990’s through ethics committees. Yet it was information’s perceived neutral position in political settings, as impartial evidence, which allowed for possible interventions into medical practice, seemingly improving technical and allocative efficiency.

The impression created during earlier attempts to transform the health discourse, the taken-for-grantedness (Ball 1993) of medical information as positive fact was used to underpin the evidence based agenda and allow for extending the notion of evidence to include cost and clinical effectiveness. The methodological foundations for analysis applied to population based administrative data allowed for changed understandings of healthcare to be developed, questioning professionalism and supporting corporatism. The association of access to information as a demonstration of freedom of choice between public and private practice in the delivery of healthcare was being formulated.

As in previous change periods, the disruption to power relations that took place led to a negotiated position, resulting in placing the right to speak on standards of cost efficient healthcare within the Victorian state government’s control. The process of systemizing information provided the possibility of redistributing power relations, constituting a right level of public spending on healthcare, allowing for reshaping expectations of a publicly provided service, and constituting medical practice as a problem of technical and allocative efficiency. A number of respondents described the reliance on formal legal powers and resources of legitimacy and authority to manage the involvement of the profession in the policy process. Explanations of administrative decisions as non political were rejected.

5.8.2 Rules establishing the limits and forms of appropriation of discourse

Strategies used by the Commonwealth in the 1920’s, 1940’s and 1970’s had created the impression that health could be managed though tighter administrative oversight. In the 1990’s a
‘right’ level of funding a public healthcare system was implied, manageable by systemized information focused on efficiency. By presenting the problem of healthcare as a technical problem of both allocative and technical efficiency, the Commonwealth, as economic manager, was able to secure authority to speak on the right level of funding for a public health system. The right level of funding could be attained by ensuring ‘efficient’ practice. Healthcare was conceptualized as a technical resource allocation problem, with the Commonwealth’s role legitimized as managing the cost efficiency of the service. Access to the discursive space was available to economists and administrators. The Commonwealth expanded its sphere of influence from the right to speak on public health issues gained in the 1920’s and 1940’s, to the right to speak about the costs of healthcare following reforms in the 1970’s, to the right to speak about cost efficiency, quality and appropriate demand and supply levers in terms of technical and resource efficiency in the 1990’s.

The NHRMC as representative of the medical profession negotiated the retention of the more elite elements of the profession, those elements which impact its social status and political power, its ability to control the creation of new knowledge through research. Increased research funding through the NHMRC, delegating veto of approvals to experienced medical researchers combined with procedures for ethics approval, allowed the profession to direct new areas of expert knowledge. Control over medical research funding remained in the hands of the NHRMC throughout the 1990’s. Expansion of health economics occurred through alternate funding mechanisms, securing legitimacy with hospital administrators.

5.8.3 The rules limiting and forming the sayable in discourse – framing the problem of health

Empirical data as positive fact presented all problems of healthcare as calculable, examinable and knowable, encouraging investigation of deviations from a norm. Issues of social justice and healthcare as a concern related to equity were silenced throughout the 1990’s. The unintended consequence for the medical profession was that the cost of healthcare could also be presented as calculable, knowable and as having deviations from a norm.

What counts as evidence, and how it is produced, and why it is produced is a process set within the political context. Information systems theories favour a method of production which emphasizes using information as a term for what is conveyed in the process of informing – the
conduit metaphor (Shannon and Weaver 1949, Bertalanffy 1968). Within the context of a general theory, information is described as a building block of an objective reality (Day, 2008). Theoretical characterizations have built on an understanding of information as a ‘scientific empirical’ discourse. This has seen the growth in applications of information in previously contentious areas: economic statistics and measures have gained legitimacy in application to constituting notions of shared responsibility and individual responsibility in health risk factors. Research efforts have encouraged a view of information as ‘out there’ to be explored, causing us to forget the purposeful stripping out of context and history.

Administrative disciplinary techniques of coding, reporting, comparing sought to influence doctors to view themselves as public servants subject to corporate control mechanisms. The act of performing these administrative tasks undermines explanations of medical practice in broad terms such as ‘art’ or ‘care’. Medical practice becomes a problem of information management and analysis. The manageability of hospital care without coordinated administrative data has become inconceivable.

5.8.4 Rules impacting the discursive dialogue

Retreating from ‘big government’ and direct intervention, while providing for private access to public funds, government tactics in the delivery of health services involved encouraging ‘self government’ of restraint and employing cost constraint. Ideas of maximizing performance and competing to do better than the ‘old ways’ are expressed in the National Competition Policy. The elevation of measures of efficiency and performance information expressed in Casemix IS, served as a measure of the worth or value of healthcare against an economic criteria. The complex social service of healthcare was translated to calculable figures or categories of judgment – costly, inefficient, and unresponsive. The new vocabulary of performance introduced a new regulative structure: the focus was not on clinical outcomes or the structures and procedures, but was to make the doctors and hospital administrators subject to measures of cost, reinforcing that constraint was of value. Competition, constraint and control were highlighted in the Casemix performance metrics. The focus on efficiency creates an acceptance of management practices such as monitoring systems, information production and economic performance metrics which seek to elevate the relevance of narrowly defined economic
efficiency metrics and create the taken-for-grantedness of the manageability of a ‘right’ level of funding of public healthcare. With respect to performance metrics, ‘truthfulness is not the point, the point is their effectiveness, both in the market or for inspection or appraisal, and in the ‘work’ they do ‘on’ and ‘in’ the organization their transformational and disciplinary impact’ (Ball 2003:224). It is the disciplinary and transformational affect of performance metrics that is desired (Ball 2003).

Casemix IS employ comparison of efficiency suggesting norms and deviations, as a means of incentive, control, and change based on rewards and sanctions. In support of management practices, quantifiable measures, which lend themselves to reporting, and are difficult to refute, became the accepted measures for accountability in Victoria with the introduction of Casemix IS: providing the Commonwealth with a proof of concept which was to be extended to other states. The role of case mix information systems has changed the relationship between doctors and managers and the discourse of medicine and health management. Casemix IS provide the ability to audit medical work practices comparing it against ‘evidence based’ best practice. The potential exists for doctors to be made more calculable in terms of the comparative performance information produced, and more calculating in terms of securing funds. Information tasked with delivering efficiency is a concept closely tied to accountability. Underpinning accountability is the idea that efficiency as the prime objective of competitive markets could deliver economic prosperity and social progress: suggesting that if governments were held accountable to economic prosperity, social progress would be achieved. Such notions require the continual provision of information to allow efficiency to be measured. The impression was created that the art of medicine could be spoken about as codifiable, the work practices of doctors as calculable to related groups, and prescriptions for service delivery could be made by analyzing Casemix data.

5.8.5 The rules limiting and forming conservation of discourse – the doctor’s clinical knowledge

Despite attempts to codify medical practice, the clinical codes used in diagnostics make it difficult for people without medical training to challenge the treatment offered. The lack of transparency into clinical decision making, while introducing market efficiencies into a public health system, encourages doctors and administrators to behave to maximize the funding
available. If the aim of Casemix IS was to better understand the activities of hospitals and resource allocation, this has been only partially delivered. The activity volumes are known, but the reasons for the activity remain unclear. With authority to speak on clinical practice, and as coders of the Casemix IS, doctors can refute/call into question public reports intended to direct practice towards policy directives. The relatively simple symbolic displays of efficiency included in Casemix IS – average length of stay – can be exposed as under representing the ‘complexities and indeterminacies’ in how hospital work is actually conducted (Covaleski, Dirsmith and Michelman, 1993:66).

The single view of hospital care provided by Casemix which applies a financial management lens to the problem of service delivery constrains alternate explanations. Explanations of quality hospital care which exclude cost in the definition of quality are deemed vague and ambiguous. Technical efficiency as an outcome of professional health services is reinforced through the act of coding clinical decisions in Casemix. The right way to practice considers the cost of resource utilization.

5.8.6 Rules which ensure that to practice is simultaneously discursive and material

That oversight is necessary to administer hospitals, and that information facilitates oversight, were both recognized as valid by the respondents. Hospitals, and practitioners, as manageable through metrics, as capable of ‘achieving’ waiting time and throughput targets, and that this was a reasonable thing, became valid statements, replacing notions of public hospitals as an expression of social equity and access.

As an approach to regulate and manage costs, Casemix IS meet an instrumentally rational objective. Efficiency comparisons between private and public hospitals become possible with ‘neutral’ metrics through centralized information systems. With the ability to monopolize legitimate documentation (specifying what will be documented and what will be ignored), a role for IS in shaping political debate can be recognized. The power of IS lies in their ability to determine legitimate documentation, ensuring aspects that fall outside the accepted categories lose legitimacy and are ignored (Lash, 2002). IS perform dual roles of providing the ability to
control costs and plays a role in depolitising the delivery of healthcare to facilitate a political exchange.

5.9 Conclusion

Accountability, evidence and the market were the policy tools which when combined became an amalgam of discourses forming the policy technology of the 1990’s deployed to transfer power from professionalism to corporatism. The idea that managing healthcare is a technical problem of regulating the right level of affordable services was established in the 1970’s. In the 1990’s, a scenario of technical and allocative inefficiency was painted, allowing for the conception of the correct level of efficiency to enable the ‘right’ level of funding to deliver a quality service. Health economics utilized concepts of information and evidence to create an idea of healthcare as a problem of managing risk and efficiency. The redefinition of the realm of central control to include responsibly funding quality healthcare in a market society involved concepts of healthcare as having a right level of funding for public healthcare when run efficiently. The right level and right quality of healthcare services were measures upon which the profession spoke about following the reforms of the 1970’s. During the 1990’s, the government was positioning competitive structures to speak about the right level and right quality of healthcare services. Ideas about information formulated in the 1940’s and 1970’s as necessary for oversight and achieving the correct level of service were utilized in the 1990’s to suggest that evidence could identify the ‘right’ level of funding for public hospitals. Accusations of anti-competitive and inefficient behavior measured by performance metrics which are assumed to describe desired quality served to shame the profession into sharing information, while establishing accountability in the governance of the profession and the sector. Elevating the importance of the expert knowledge of hospital administrators reshaped the relationship between doctor and administrator positioning new voices in shaping the right way to practice, in line with government objectives of ‘cost efficient’ practice. Accountability, evidence, and ideas about competition in a market economy created an environment in which re-examination of what was considered of value in healthcare was undertaken: limiting the reaction to change. Attempts to constitute medical practice as manageable through metrics were accepted in exchange for autonomy, including setting the clinical codes used in Casemix IS. The unintended consequence of this was the profession could call into question the validity of performance metrics used to shape practice.
The role ascribed to the negotiated information systems reflected the accord reached regarding authority to speak: the right level of funding for public hospitals fell under Commonwealth control and reflected the problem of healthcare as technical and allocative inefficiency: practice information fell under the professions control reflecting clinical decisions as within professional jurisdiction.

The constraints and possibilities for influencing the health discourse have been analysed. Health economics was denied access to medical research funding, but managed to position efficiency and effectiveness in the health discourse. The construct of the ethical professional which had been bruised in the 1970’s, was not disrupted in the early 1990’s, though the potential for performance metrics to shame professionals existed. The mutually interdependent relationship between the government as purchaser and the profession as provider was made possible by a view of central management as constrained by information flows controlled by doctors. The idea that the medical professional is pivotal in health information collection and dissemination continued despite the deployment of Casemix.

The task of the next chapter will focus on understanding the role of eHealth in the wider reform process, and seeks to illuminate the potential impact on adoption of health informatics. The renegotiated information systems being examined in the next chapter are ‘eHealth’ systems which have failed to materialize. Despite the hindrance this places on ‘its explanation in conventional terms of technical or social appropriateness, or even of success or failure’ (Doolin 1999:96), the information system in question had a subjective existence. The various actors involved in eHealth initiatives and those acting in relation to it provide the data for the next chapter, the focus remains the transformation of the discursive forms of healthcare.
Chapter 6

Practitioners and the Discourse of eHealth

6.1 Introduction

This chapter will focus on gaining an understanding of the climate of change that exists, and the ideas being diffused through eHealth (1997 to present). eHealth is a term encompassing on-line health service delivery initiatives which began in Australia with the tabling in parliament of the ‘Health On Line’ report in 1997. The chapter is concerned with how the discourse of health is being impacted by ideas diffused in eHealth initiatives. How ideas about health are being constrained is also an area of interest. As in previous chapters, the focus is on how the problem of health is being framed to suggest eHealth as a potential solution. The ideas being contested which may lead to a renegotiated system is of particular interest in this thesis.

The infrastructure necessary to facilitate an environment in which eHealth becomes a component of the health system is being deployed in Australia. A personally controlled patient record is currently being piloted (NEHTA, 2011). Told through the experiences of key players in the Australian health setting, the translation of policy to practice is explored. A mixture of medical professionals, administrators and other influentials’ describe the current period of transition exposing the discursive mutations taking place. Understandings of eHealth today are understood to have been shaped by ideas diffused in past reforms in particular during the introduction of health online. As in the previous chapters, critical events which demonstrate the redefinition of the realm of central control in the management of healthcare, specifically in relation to the systemization of information, will highlight points of resistance and change. The migration of public health services and preventive medicine from Government interest to the private business model provides the focus. The changing role of the Commonwealth Government, and the way in which its boundaries are defined will be examined.
To this stage the study has argued that the systemization of information was used as a means of deploying reform ideas into practice. The role assumed by the Commonwealth resulting from the negotiation of these ideas has been examined in light of the overarching goal of a nationalized health system. In the previous chapter, the climate of change which was created during the transition to a market economy was examined. The early 1990’s saw the diffusion of the discourse of accountability and evidence into practice through Casemix IS which elevated the positioning of cost and clinical efficiency in assessments of the performance of the health system. Popular support for a public health system limited the opportunities for micro economic reform, while ensuring Government a continuing role in funding the system. Assuming responsibility to fund a universally accessible public health service, while maintaining a policy of distancing itself from direct service provision and simultaneously supporting competitive structures, are resulting in policies in which investigator-driven research is being rewarded at the same time as priority-driven research is being advocated: evidence based practice is being encouraged at the same time as patient-centric consumer choice approaches to practice are being rewarded.

This chapter will begin by exploring the environment which existed during the introduction of the ‘Health On Line’ report in the late 1990’s. This report signifies the beginning of the current eHealth infrastructure projects. The intention is to gain a greater understanding of the role of systemization of information in political exchanges. As with the previous two chapters, the focus is on the transformation of the discursive forms of healthcare. The chapter concludes by analyzing the set of rules which determine the discursive space in which healthcare, and in particular health informatics, operates. The impact of diffused practices on current reform efforts will be explored.

*Data introduced in this chapter*

This chapter draws on interview data from 19 influential players in the health setting to address the question: What are the taken-for-granted perceptions of information in healthcare? and which ideas are contested? The players have varying perspectives, from those who are actively involved in the deployment of infrastructure to those who will be influential in encouraging or discouraging adoption of eHealth initiatives.
This chapter also draws on data from documentary sources, including Government policy documents, Government discussion papers, departmental records and reports, annual reports, commissioned reports, Australian Bureau of Statistics data, Australian Public Service database, media releases and meeting minutes, and secondary sources such as newspaper articles and academic literature.

6.2 Background

Medicare Australia is described as a prescribed agency under the Financial Management and Accountability (FMA) Act 1997 (Medicare Australia). The FMA Act (1997) sets out the requirements for agencies which collectively comprise the legal entity, ‘the Commonwealth’ (FMA Act 1997), and identifies outcomes as the measure of accountability. The Commonwealth Government’s continued commitment to funding healthcare was reaffirmed in the Act (1997), guaranteeing continued public funding to the health system. Despite John Howard’s (Prime Minister, 1996-2007) ideological opposition to Medicare - in ‘Future Directions’ Howard (1988) said of the Medicare scheme: Australia's health care system is in a shambles. The real villain is Labor's doctrinaire commitment to a universal Government health insurance system, Medicare. By discouraging self-provision, by increasing health funding from the taxpayer and removing disincentives to overuse of medical services, Medicare has created a system obsessed with cost at the expense of quality, security and comfort (Howard 1988) – responsibility to maintain a popularly supported universal health system was accepted. The underpinning idea of community responsibility for healthcare was not accepted. Government policy would pursue supply and demand levers which could shape the behaviour of patients and doctors.

Continuing to recognize its role in building a market society, the role of Government in the conservative Howard Government was in support of competitive market structures. The commitment to the fee-for-service biomedical model was emphasized by Howard in his review of their record:

- Since 1996 spending on Medicare has increased by almost $2 billion - from $6 billion to almost $8 billion a year. Australian Government expenditure on General Practice (including Medicare rebates, the Practice Incentive Program and the
General Practice Immunization Incentives) have increased by about 30% over the past six years.
- Record funding for Australia's world-leading Pharmaceutical Benefits Scheme. In 1991, the cost of the scheme was $1 billion and it is now nearly $5 billion. The PBS gives affordable access to medicines for all Australians.

(Howard, 2003, Media release ‘Medicare for all Australians’)

The reforms of the 1980’s and 1990’s had suggested a right level of funding for a public system, describing the problem of healthcare as a technical issue of providing services within budget. The proportion of recurrent health services expenditure between 1989 and 1996 fell from 32.3% to 28.3% in public acute hospitals, while it increased over the same period from 6.3% to 8.3% in private hospitals (AIHW, 1996). Constrained by Government spending cuts, and impacted by a drop in the proportion of income claimed from privately funded patients - ‘In 1991 27% of privately insured people were treated in public hospitals: this is now around 15%’ (Senator Minchin, 8th December 1998, Hansard:1390) - public hospitals were placed under pressure to meet targets. Portrayed as struggling to cope, private health insurance was the suggested solution to a viable public health system – ‘we on this side of the chamber believe that private health care is an essential part of the total health package in this country. People are entitled to choice and are entitled to best quality care and they are most likely to achieve that if you have a strong public sector health system and a strong private health sector’ (Senator Hill, 30th November 1998, Hansard). The idea that choice and diversity are solutions to inefficiency was being promoted. To create a strong private health sector, participation in private health insurance was proposed ‘this is necessary to allow those persons who are prepared to take responsibility for their own health care to be able to afford to do so’ (Senator Mac Gibbon, 8th December, 1998, Hansard:1409). Notions of responsible people as those who ask for little or nothing from the state were being promoted. Acknowledging that the costs of private health insurance premiums were too high to encourage participation, a non means-tested rebate was suggested. The Private Health Insurance Incentives Act was passed in December 1998, widening the scope of private for profit organizations accessing public funds for provision of healthcare services.

6.2.1 Health Online

The 1997 Health Online report presented to parliament findings on the potential of developments in information management and information technology in the health sector, determining the
feasibility of Australia creating a market in this new technology. Health informatics was defined to include health information management and telemedicine, including the practice of medicine and the delivery of health services by interactive videoconferencing facilities (Health On Line, 1997). In July 1998, the National Health Information Management Advisory Council (NHIMAC) was established to promote a nationally uniform approach to more effective information management in the health sector (HealthConnect 2003). Health Online: A Health Information Action Plan for Australia was released by NHIMAC in November 1999 as a framework providing the basis for a nationally collaborative approach to using information in the health system (HealthConnect 2003). The scope of health policy utilizing health informatics extended beyond acquiring and disseminating data to issues of practice reform.

With shifts in emphasis in the health care system to health outcomes, the interests of public health and individual health care converge. This view is gaining acceptance amongst State Governments who support the concept of evidence based medicine and the strategic use of Health Informatics as essential to new ways of delivering health care and enabling the measurement of clinical outcomes. (Slipper, Forrest, Health On Line, 1997:60)

No longer simply a means of collecting and disseminating information, health informatics was being envisaged as having the ability to transform healthcare. The intention was to merge public health principles into a private practice model, diffusing these ideas into practice through informatics. Predicated on the belief that quality healthcare requires management oversight, the idea that quality healthcare outcomes could be and should be measured and managed was being formulated.

The idea that quality healthcare requires management oversight was supported by the publication of the Quality in Australian Health Care Study (QAHCS) authored by Wilson, Runciman, Gibberd, Harrison, Newby and Hamilton in 1995. The publication of the report represented a defining moment for Australian health care providers (Weyden, van der 1995, Siddins 2002, McDonald 2000). The study presented findings that 16.6 per cent of hospital admissions were associated with an adverse event and 51 per cent of the adverse events were considered preventable (Wilson, Runciman, Gibberd, Harrison, Newby, and Hamilton, 1995:459). It led to the establishment of an Australian Council for Safety and Quality in Health Care in 1999, set up to facilitate national actions to improve safety and quality (Siddins 2002). Quality became an
important element of a number of reviews, including the General Practice Strategy Review in 1998 (General Practice Strategy Review Group 1998). The Australian Institute of Health and Welfare, which developed a set of forty performance metrics for the health system, ten of which related specifically to quality, noted the extent to which performance metrics are deployed in healthcare:

There are considerable overlaps between this set and the Reform Commission’s proposed performance indicators. There are also intersections between this set and the National Health Sector Performance Indicators reported to Health Ministers by AHMAC in 2003, and most recently reported, at the request of Health Ministers, in Australia’s Health 2008 (AIHW 2008)

The external scrutiny of professional practice has questioned notions of quality healthcare as a natural consequence of a sound medical education, accreditation and good intentions on the part of medical practitioners. Quality has increasingly been considered within the arena of accountability and responsibility (Australian Patient Safety Foundation 1998, Leatherman and Sutherland 1998, Fletcher 2000). The judgment passed by the QAHCS (1995) study was that the self regulated medical professional practice was not trustworthy: ‘The general question on system error was only answered positively for 16% of AEs (adverse events) … The low proportion in this study may reflect difficulties eliciting such data either from the medical record, or from sections of the RF2 (reason for), or the reticence of the MOs (medical officers) to invoke these factors’ (Wilson, Runciman, Gibberd, Harrison, Newby and Hamilton 1995:471). The lack of data in medical records and the difficulty this presented in assigning causation, combined with a reluctance by the profession to suggest blame, were highlighted in the report as impacting upon an understanding of adverse events that would lead to changed behavior (Wilson et al 1995:462,464, 469, 471). The report led to the establishment of the Taskforce on Quality in Australian Healthcare in June 1995 (Australian Health Ministers’ Advisory Council 1996). Further, the study questioned the appropriateness of the existing professional structures to meet consumer quality demands: ‘The implications of our study in terms of preventable adverse outcomes for patients and the use of health resources are substantial’ (Wilson et al, 1995:459). Fletcher (2000) cites a five-nation survey examining public attitudes which suggests ‘there has been a ‘substantial loss’ of public confidence in the healthcare system over the past decade, particularly marked in Canada and Australia’ (cited in Fletcher 2000:3). The legitimacy of
professionalism and self-regulation as a governance mode for healthcare was being replaced by faith in the regulated market as a governance mode.

Health Online (1997) proposed a health system where consumers would demand quality health services which were based on public health principles, to manage their health outcomes supported by competitive structures. Health Online (1997) proposes evidence based practice and informatics as the transformative agents in healthcare. These transformative agents would underpin the notion that efficacy data provides a picture of effective outcomes, and an understanding of health outcomes as manageable.

This chapter continues by examining how the discursive forms of healthcare are being transformed to view informatics as a common sense approach to delivering manageable quality health outcomes. The means by which the interests of public health and individual health care are being converged and the disciplinary techniques and policy tools used to encourage this convergence are examined. The means by which patients’ interest in managing their health outcomes and doctors’ interest in assisting in this management is being shaped will be studied. The set of conditions which are making it possible for transformation to occur is the focus. The aim is to identify the change environment for action.

6.3 The Displacement of Boundaries

Preventative healthcare falls within the jurisdiction of public health which takes a population level disease focussed view of healthcare. Public health, and preventative healthcare, has been an area of Government concern since the establishment of a Commonwealth Department of Health (see Chapter 4 for a detailed discussion). Reforms aimed at elevating the position of preventative medicine and at promoting a disease based view of healthcare are reshaping professional boundaries, in this way the convergence of public health principles with individual service delivery is being enacted. Participants discuss the conditions which are presently impacting the professional boundaries. Participants discuss the diffusion of a preventative disease focussed view of healthcare and the reshaping of professional boundaries to allow other
voices to influence an understanding of health outcomes as manageable. Potential roles for eHealth in supporting new ways of understandings healthcare are proposed by participants.

6.3.1 Using existing institutional structures to support preventative healthcare

Perceptions of quality issues in healthcare, created through output performance metrics, provide the possibility for greater scrutiny. Increasingly the performance outcomes of general practitioners are linked to meeting requirements to prevent hospitalization. This has been translated in the primary and community care performance benchmark as:

By 2014-15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions.
(Steering Committee for the Review of Government Service Provision, 2009)

Prevention and the understanding of how risk factors should be controlled in individual patients provides the shifting terrain on which the principles of public health and population based care operate in privatized practice. All participants in the study included in their description of the problem of healthcare the rising incidents of chronic disease and suggested the potential of self managed preventative measures as a possible solution.

A need to shape patients understanding of disease to include viewing preventative treatments of risk symptoms as disease management was expressed by MA1, MA2, MA3 and CR3, and is articulate here by MA4 as:

It gets down to the prevention and the primary care model that is clearly the focus of the reform agenda at the moment. If you look at a persons assessment of their own health and well being, most people think that they are going OK even if they are carrying quite complex and underpinning chronic indicators. Their bloods could be all over the place, they could have a heart problem, but they don’t count themselves as having a heart problem because they’re on a medication that is controlling that heart problem
(CEO Victorian Healthcare Association, MA4)

The possibility for preventative care in patient understanding of health services is constrained by views of curative medical interventions as normal. Describing the concentration of current
reforms on prevention, MA4 identifies perceived consumer need - the patient market for preventative risk management – as currently lacking. Implicitly this response indicates that prevention requires providers of healthcare to assist patients in understanding their risk and suggesting management approaches.

Across the various groups participants suggested a concept of healthcare as a service concerned with preventable symptoms and including advice and interventions. The new areas of expert knowledge that this has created, and the expansion of professional groups participating in, and speaking about, treatment was recognized by MR1 as:

In the past the GP of someone with diabetes knew everything about that patient, was able to see them relatively frequently, was able to manage them pretty well. Nowadays, no GP I know has any concept of all of the variations of insulin. They will often have moderate levels of knowledge about dietetics but they don’t have the ability to provide dietary advice that the dietitian has, and so it goes. Funding has driven short visits to GP’s, and in the current system, everything says to the GP see this patient in 6 minutes or the practice starts to lose money. Anyone who thinks they can get their head around each of the allied health professions areas has to be mad. There is a huge amount of knowledge that each of the professions holds and uses. We need to respect the members of each specialty.
(Chronic Disease Director, MR1).

In December 2006 the United Nations General Assembly voted to pass Resolution 61/225 declaring diabetes an international public health issue (cited Zimmet and Magliano, 2010). The increase in the proportion of people over 65, and urbanization, are linked to the prevalence of diabetes (Wild, Roglic, Green, Sicree, King 2004). Increasing evidence of effective interventions, including changes in diet and physical activity or pharmacological treatment to reduce prevalence of diabetes, has suggested the potential of preventive approaches (Wild et al, 2004). ‘Cardiovascular disease (CVD), diabetes and chronic kidney disease (CKD) account for around a quarter of the burden of disease in Australia, and just under two-thirds of all deaths. These three diseases often occur together and share risk factors, such as physical inactivity, overweight and obesity, and high blood pressure’ (AIHW, 2009). The rising incidences of preventable disease are suggesting inadequacies in the curative medicine model and have raised questions about the best way to achieve quality health outcomes. Interventionist approaches alone are considered inappropriate to preventing the rise in reported incidence of diabetes.
Describing the relationship between the doctor and the patient in corporatised medicine as less intimate, the focus on time and cost is cited as the cause of poor quality health outcomes by MR1 above. Identifying issues with specialization, recognizing limitations in the expert knowledge of general practitioners and autonomous decision making, MR1 highlights the constraints placed on professionalism in a competitive corporate healthcare market as impacting outcomes. The impact of corporatisation on professional work practices was a common theme amongst the medical professionals. Tension between professional groups vying for jurisdiction in the preventative market was suggested. Supporting views on the tension that expanding the professional activities was introducing, MR2 states:

You now have psychologists and others able to claim on MBS, further entrenching professional groups and expanding the rebates. All of these stakeholder groups protecting their area, it is not going to make a more equitable health system.

(President of the Doctors Reform Commission, MR2)

The respondent is highlighting the issue of managing an expanding market for professional preventative/risk management services in a publicly funded system, an issue also raised by MR3 and MR5. A greater call on medical services and testing of individuals has expanded the services calling on rebates: ‘The increasing emphasis on management of chronic disease in the community, and on secondary and tertiary prevention could be expected to lead to continuing increases in pathology ordering by GPs’ (AIHW 2002:62). ‘The number of pathology tests/batteries ordered increased significantly by 43%, from 21 to 29 orders per 100 problems’ between 2000 and 2009/10 (AIHW, 2010:x). Interventionist professional services aimed at the individual preventative risk management market are adding to the costs of publicly funded healthcare.

A view that change is required was universally accepted across all participants. Across all of the medical participants a view of the fee-for-service model as inappropriate in an expanded view of healthcare was expressed, though explanations of causation varied.
6.3.2 Difficulties in translating ideas about self management of preventative risk factors into practice.

For MR1, MR2, MR3, and MR4 the demands of commercial practice and cost containment measures were regarded as introducing inadequacies in the fee-for-service system. MR2, MR3 and MR4 posited poor central planning as introducing inefficiencies into an already strained system. For these participants ideas about the inadequacy of the existing system are supported by management issues introduced through the promotion of professional services in support of a preventative/self management model. MR3 illustrates the impact in practice:

There is technology available, there are tests available and people want certainty. I can’t tell you the number of times I have a child with a headache and the family wants an MRI, on so many levels that is not right. It takes time to convince the family it is not needed and I know in many instances clinicians will simply do the test.
(Pediatric lead, MR3)

MR3 identifies the co-ordination of risk management activities, and dispensing of care advice which supports a disease focused preventive view of healthcare as contradictory to administrative aims of cost containment. The response describes as commonplace the prioritization of patient satisfaction over efficient practice, suggesting the idea that efficacy data provides a picture of effective outcomes is an area of contestation. Implicit in the response is a view that patients are driving demand for the curative risk management approach, demanding this approach over self management risk avoidance methods. MR3 suggests that sensitivity to resource utilization is creating support for a view of the existing system as inappropriate, with causation attributed to patient over utilization. A view of the system as inadequate is expressed.

6.3.3 Difficulties in translating ideas about healthcare outcomes as manageable

Translating into practice ideas about healthcare as a disease preventative risk management issue which involves patients in self management accentuates the tension between ‘care’ and ‘administration’. The tension between care and administration was mentioned by all medical participants, those involved in administration MA1 and MA3, and those involved in deploying eHealth solutions CR1, CR2 and CR4. The tension was invariably mentioned as part of the
fabric of a health system, a taken-for-granted element. MR3 provides an illustration of the impact of this tension on practice:

I think it needs an emphasis shift, the organisation model is very corporate but the service delivery is still modelled on the way it was – it still comes down to an interaction between two people. I think there is a mismatch between what happens at the coal face and what happens in the planning. We’ve created efficiencies I guess: at the hospital we’ve created care plans for everything imaginable. There is a care plan for the child with asthma, there is a care plan for this and a care plan for that. That can be efficient … you’re still dealing with a dynamic system which is a person and you have to be responsive to the person there. That is how inefficiencies happen. (Pediatric lead, MR3)

Disease focused care plans identify the full range of needs of the patient and actions required (shaped by best practice evidence) and includes management goals agreed between patients and their doctor (Department of Health and Ageing, 2011). The participant suggests an understanding that the concept of healthcare as a disease and preventative/risk management problem is underpinning care plans in practice. The respondent explicitly identifies the doctor patient relationship as non responsive to management mechanisms underpinning care plans. The response highlights the conflict that exists between views of the practice of patient care as more complex than the routine and systematic descriptions of a care plan, while acknowledging that this lays it bare to accusations of inefficiency. MR3 is suggesting that prescriptive systems of care delivery are not flexible and adaptive enough to deal with care as a dynamic human service. Implicit in MR3’s response is that only doctors can determine the right way to practice patient care.

Ideas about health outcomes as manageable underpin evidence based care plans. A care plan solutions provider (CR1) suggests skepticism amongst professional groups about the appropriateness of administrative management tools in affecting health outcomes is widespread:

If care plans are used properly and followed up and patients follow them up, they’re great. But if they’re used as a means of getting an MBS item payments, which is what they currently are, then everyone treats them with cynicism. So they say, I’ll do it, but only because that’s the way the patient gets the rebate they want with the allied health provider. There is a lot of skepticism about improving outcomes.
The respondent suggests that the ideas underpinning the care plans which relate to healthcare as a risk management issue are being undermined. CR1 describes the strategy used for resisting practices which underpin the ideas of healthcare as a risk management issue: adopting changed funding administration practices while undermining patient care practice change. A view that diffusing ideas about service delivery through administrative practices will be ineffective at bringing about practice behavioral change is expressed.

A view of health outcomes as manageable through the use of care plans is supported by the idea that efficacy data provides a picture of effective health outcomes.

If I take care plans as an example, say you can make care plans more efficiently, earn more money, get better health outcomes, that’s what the evidence says, you’d think they’d all adopt them...

(CEO health informatics solutions provider and Professor within the Department of Medicine, CR1)

As an area of contestation, efficacy data was recognized by CR1 to fall short of the compelling evidence required by the profession to shape medical professional ideas about the manageability of health outcomes:

Even if you could improve the outcomes you would have to show, at the minimum that it wouldn’t cost them more, and preferably, they would actually benefit financially. … If you had really compelling evidence they’d do it…… Initially we tried GP’s, but then the issue is ‘is it quality of care’ you’re looking at or is revenue: they don’t like it if you just say we’re going to increase revenue. They do want you to say you’re going to improve care.

(CEO health informatics solutions provider and Professor within the Department of Medicine, CR1)

The response describes the resistance met to the ideas embedded in care plans when they are presented as providing a picture of effective health outcomes. The response suggests that non refutable evidence, epistemological demonstrations to which the profession accord value, is necessary to bring about behavioral change. Explicitly voiced in the response is the clear divide that exists for the profession between ‘care’ and ‘administration’, with the notion of ‘care’ being
more difficult for non clinicians to claim. Reflecting the tension between administration and care, the respondent implies an understanding of notions of ‘care’ as a strategy for resistance.

6.3.4 Difficulties in influencing existing institutional structures

Providing epistemological demonstrations in support of the manageability of health outcomes is difficult. A practitioner with a role in deploying eHealth solutions describes:

Much of the hospitals investment is based around reporting and data collation rather than clinical outcomes. There is a distinct lack of clinical focus as opposed to data collation and justification etc. The clinical data I mean is when community health go to visit Doris they see she doesn’t have a seat in the shower. The doctor sees that in her record and says we should get an OT out to set that up for you. This gets no priority over an MRI scan. If you spend a lot of money on an MRI machine you’d better get your money’s worth. Still the MRI information and information from pathology and radiology easily connect to a central store. Getting the useful information about Doris is much harder because it includes what she ate for dinner, and so on. The information is clutter. An MRI result I can say yes/no to a problem. (eHealth and Business Development Portfolio Manager, CR2)

The respondent highlights the difficulty experienced in providing compelling evidence about the effectiveness of the risk management view of healthcare. The difficulty in expressed as the multitude of data sources which a risk management approach to healthcare calls upon, the coordination of the various players, the coordination of the data set against the commercial attractiveness and integration of the biomedical alternatives. The respondent identifies the entrenched application of technology in support of service delivery in a curative medicine model. Implicit in CR2’s response is recognition of the commercial unattractiveness of service delivery in a complex holistic risk management view of healthcare.

6.3.5 The potential of disciplinary techniques to bring about behavioural change

In practice the act of coding and typing care plans is subjecting the clinicians to administrative techniques and changing behavior:
It is not that the formality or informality would make a difference to the target audience, it is just that if I’m typing it up, it would feel like a more formal document. For example in the hand written notes I would say ‘thanks to the resident for reviewing patient overnight’, I would probably use more informal language in the notes that are hand written than I would feel I had permission to use in something I was physically typing up. If I was typing I’d make sure my spelling was OK, that my capitals were in the right place and it was formatted properly and that would take energy… If I was writing notes I’d put more of myself into it. If I was typing that document it would have to be a more formal document.

(Pediatric lead, MR3)

For MR3 the physical act of typing patient information in a shared care plan has changed perceptions of the collegial conversations which hand written notes represented to acknowledge the disciplinary potential of more formal structures. MR3 describes an awareness of an audience beyond medical colleagues which come with formal processes such as care plans. The way of interacting with the medical record in a shared care plan has the potential to change the behaviour of the clinician to cause self awareness constraining the conversation between colleagues to reflect professional corporate norms.

6.3.6 Summary of the changing boundaries of professional activity

All participants interviewed indicated shortcomings with the existing healthcare system, and indicated a role for a preventative self management approach. Explanations for causation of inadequacies in the system varied. Participants’ identified management issues introduced through the promotion of professional services in support of a preventative/self management model, delivered through commercial fee-for-service enterprises as supporting a view of the health system as inadequate. Inadequacies were identified in central planning, professional and experiential knowledge, patient understanding of prevention and expectations of quick fix curative approaches, the prescriptive nature of care plans, the demands of commercial practice for throughput rather than care. Respondents indicated that a climate for change is being created in which the activities of the profession are being shaped by a changing conceptualization of health outcomes as manageable. This concept of healthcare changes professional activities to combine care and administration: the interviews indicate the tension this introduces is undermining diffusion of the idea that efficacy data describes effective outcomes. Collecting data to provide evidence in support of a view of healthcare as manageable is complicated by the
commercial realities of the existing institutional arrangements, and the technologies which support these arrangements.

6.4 The Displacement of Boundaries defining Manageable Healthcare

Participants promoting eHealth (primarily CR1, CR2, CR3 and CR4) are positioning health informatics as a potential solution to the inadequacies of the current system. eHealth is being positioned to embrace a concept of healthcare concerned with the management of outcomes, focussing on a preventative approach which includes advice and interventions. Understandings of health outcomes are influenced by context and perspectives, suggesting a reason for the varying roles described for eHealth by participants.

6.4.1 Managing resource utilisation

The potential of eHealth to act as a disciplining technology to influence lifestyle choices in support of self management and cost containment was suggested by a representative of the National eHealth and transition authority. NEHTA is a Government authority falling under the Department of Health and Ageing it was established in 2005 as a collaborative enterprise by the Commonwealth, State and Territory Governments (NEHTA, 2011):

There is a thing called the CHAT study which Henry Krum in Victoria did. It looked at people recording in their mobile phones their heart rate, it had an algorithm it would send them sms’s. They had a 30% reduction in hospital readmissions, from an incredibly cheap solution. That is one of the challenges for IT at the moment. The gap at the moment is good systematic ways of measuring, capturing and recording what works.

(General Manager Implementation, NEHTA, CR3)

CR3 explicitly advocates a role for informatics in addressing the issue of preventable hospital admissions through self management, while implicitly suggesting informaticians have a role in determining the right way to deliver health services. The need for evidence to secure a non refutable position is also acknowledged. The Chronic Heart Failure Assistance by Telephone study (CHAT), assessed nurse coordinated phone support of patients with chronic heart failure (Yallop, Chan, Piterman, Tonkin, Forbes, Davidson, Clark, Halcomb, Nagle, Stewart, Croucher, and Krum 2006). Using interactive voice response software, prerecorded telephone chronic heart failure management scripts based on evidence based protocols were used to monitor and advise
patients about risk management behaviour (Yallop et al 2006). CR3 measures the success of eHealth as meeting management aims of reducing resource utilization.

6.4.2 Managing improved productivity

Beyond resource utilization, eHealth is being promoted to address the inadequacies in the current system viewed as inhibiting self management of disease. This role for eHealth is in support of a Government interest in improving productivity by delegating responsibility for health outcomes. NEHTA’s general manager states:

In terms of productivity, the two big gains are one in terms of hand over of care and there is lots of evidence of problems there. Loss of information and misalignment of expectations. The model of general practice is changing too. It is happening subtly but will happen more strongly over the next decade. People are increasingly made to take responsibility for the management of their care. If you actually had decent health summary profiles that could get you to say, ‘here you swipe my card and you’ll see what type of green pill I’m on’, it is great for elderly patients and support for carers too. With an aging population and support of carers is going to become a big issue. The work doctors do now nurses will do in ten years, and the work nurses do now people will do for themselves. And there is that shift downstream. Part of that is about how do you give people the tools to do that.

(General Manager Implementation, NEHTA, CR3)

The task of managing the disease risk factors and the risk of resource usage is to be delegated to patients who will be facilitated by access to information. The response describes information asymmetry as limiting self management, and information systems as addressing this limitation. While on the one hand recognizing that patients are being made to take responsibility for managing their care, the respondent suggests that this is what patients want. Implicit in the response is the view that the skills, and professional and experiential knowledge held by doctors and nurses can be readily transferred downstream by providing access to information. CR3 explains that this will require a shift in the key relationship in care from the doctor patient relationship to an informed patient provider relationship as patients take responsibility for management of their care over time. Such a change would reshape professional boundaries, potentially constraining the activities of the profession. Information systems are being proposed as the tools which will facilitate this exchange.
Addressing the inadequacy of reliance on autonomous professional and experiential knowledge in a disease focused, preventative/risk management approach to healthcare, informatics is suggested as a knowledge management and co-ordination tool.

… If you look at it, one of the implications of say patients looking after themselves and giving them more routine things, you’re pushing up the casemix of cases actually hitting the GP’s and the hospitals. The intelligent management of a knowledge base of that scale is huge. There are tools appearing like map of medicine and so on that are heading in that direction.
(General Manager Implementation, NEHTA, CR3)

Explicit in CR3’s response is the view that professional judgment involves routine decision making and the systemization of information will address the complex decision making necessary in a risk management model. This view contradicts the view expressed by the medical respondents above who suggest ‘care’ as a dynamic human service. The response describes the creation of an external knowledge base implicitly suggesting that the professions claim to expert knowledge will become intangible in the future. Implicit in the response is a view that the skill level of medical professionals is limiting a more sophisticated approach to healthcare.

Questioning whether knowledge transfers downward to improve health literacy will be effective for all patients, one medical respondent suggests the devolution of responsibility could have the unintended consequence of increasing resource utilization:

Allowing patients to read their record may help some of the time, it may be advantageous some of the time and it may be annoying some of the time. There would be potentially positives and negatives. Patients checking their blood test results without appreciating that you can have a lot of anomalies without it leading to anything. Some people will be disadvantaged by seeing those results and will ask for more investigation. Whereas other people might ask the right questions – why does the blood say this? – well it probably indicates you drink too much alcohol – then I should cut down. The interpretation of information is key.
(General Physician, Director General Medicine and Chronic Diseases, MR4)

The respondent describes an understanding of the desire to change patient behavior through access to information contained in patient records. Indicating that there are ‘right questions’ leading to right behaviors which would result in changed lifestyle choices, the respondent suggests ‘the wrong’ interpretation will result in more intervention. MA4 is suggesting that
providing access to information without informing the required interpretation will lead to unintended consequences.

6.4.3 Managing the administration of routine tasks

Alternative explanations distance eHealth from a direct challenge to professional expert knowledge and the ‘care’ process, while recognizing a role for information systems in addressing the inadequacies of relying on autonomous professional decision making. CR2, CR1, CR4 and MA5 and medical respondents all suggested a role for eHealth in the administration of routine tasks. CR2, who is actively engaged in deploying eHealth solutions within public health organization, highlights the need for information systems to address inefficiencies in resource usage due to communication coordination:

Our vision is that people with chronic diseases who’ve got multiple service providers providing input, and with no clear coordination of those… Our plan is to recruit people through their GP’s and get them that way. You’ll still have hospitals, the nurses and the same tests. You just might not need as many, or have the same one happen 5 times. Or you’ll need more because you’ll be getting the right one that you didn’t have before because you have a decision support system there that says 3rd day post op needs a haemoglobin test. It is not going to change the kind of care or service, just when and the frequency of care.
(eHealth and Business Development Portfolio Manager, CR2)

At pains to suggest that the current institutional arrangements will be retained, CR2 positions eHealth to enhance communication structures rather than threaten the status quo. This view of eHealth found support among the professional participants, typical of the responses was this comment from MR4:

The real beneficiary is the patient – without question they have a reduced risk. The patient will get good communication between their health providers. If you look at discharge summaries and referrals to allied health staff, they are awful. When people present at hospitals we need to know what patients are allergic to.
(General Physician, Director General Medicine, MR4)

Supporting a role for information systems in addressing inadequacies related to reliance on autonomous professional and experiential knowledge, a role in housing the knowledge base
drawn on for diagnostic/treatment decision making was suggested. Medical respondents suggested the retention of the existing knowledge base and organizational structure, while acknowledging a role for eHealth in improving the quality of information being exchanged between professional groups in support of patient care activities. Ideas about autonomous professional experiential decision making as inadequate in a disease focused preventative/risk management view of healthcare underpin the role proposed for information systems in support of knowledge management and collaboration.

Reducing the administrative burden of preparing care plans with multiple data sources, and addressing ease of use issues with the practice of care plan use, was proposed as a role eHealth could assume by CR2:

> GP’s would have access to clinical systems at the hospital. They could see what’s happened to the person when they’re there. Lots of different systems could upload. Lots of different systems would be compatible. I still think information will exist in silos. The GP will create a summary but he’s not going to let go of everything that he’s got. He’s just not because it’s his. There will be a lot more focus on care coordination, care planning and care groups. The right technology will greatly help (eHealth and Business Development Portfolio Manager, CR2)

Describing the mechanics of an Information System which would ease the use of care plans, CR2 identifies the underpinning idea of health outcomes as a management issue involving various providers as difficult to diffuse in practice. CR2 suggests that the profession will continue to make autonomous decisions despite processes which encourage information sharing. CR2 does not use the word collaboration, preferring coordination, planning and groups. Despite the desire to impact ‘care’, CR2 identifies eHealth’s role as facilitating administrative functions, rather than supporting care practice change. Acceptance of explanations of professional resistance to collaborative approaches and a narrow role for eHealth in support of this explanation was not universal:

> But, the way care plans were introduced, because there are no enabling technologies they are very hard to do. So, it would take GP’s a long time to do a good one. And to do a poor one, they get paid the same amount for it. A poor one is of no use. 70% of GP’s
would see care plans as a terrible administrative burden and with nothing gained for the patient because of the ways they’re used currently. (CEO health informatics solutions provider and Professor within the Department of Medicine, CR1)

CR1 is suggesting that the introduction of technology could provide seamless administration, addressing ease of use issues, which would encourage the correct use of care plans when evidence of efficacy is provided. Explicitly described is a need for financial incentives or penalties to ensure compliance. Implicitly CR1 indicates the desire to collect data through care plans to facilitate the provision of compelling evidence for a risk management view of healthcare in order to reshape professional boundaries.

6.4.4 Managing quality and safety

Beyond cost efficiencies and administration tasks, a role for informatics in improving quality and safety was suggested by medical respondents MR1, MR4, MR5, MR6, administrative respondents MA1, MA2, MA5, and corporate respondents CR1, CR2, CR3 and CR4. The CEO of an eHealth solutions provider articulated the link between multi provider team communication and quality and safety that had been widely mentioned by participants:

In healthcare, Australia has a relative competitive advantage. Health Informatics could be the last frontier. There is a real opportunity for Australia here. There is an opportunity to address the big problems in the health system, it should be more efficient, have higher quality, and improved safety. These could be fixed through more appropriate use of IT. We have too many hospital admissions, we don’t need so many. We have chronic disease which is a huge problem and our health system is not set up to do it. It can’t do it unless you use IT or collaborative technologies to enable care to take place over various care providers. The transaction costs associated with the collaboration are overwhelming, so you can’t scale it. All of those things affect quality and safety and the lack of decent IT to support what I think needs to be addressed.

(CEO health informatics solutions provider and Professor within the Department of Medicine, CR1)

The disease focused approach to care supports expanding the involvement of professional groups beyond the general practitioner suggesting the need for collaboration and information sharing. The respondent positions information systems to resolve the inadequacies of the current system, claiming to achieve the dual aims of supporting a disease focused preventative/risk management
model which limits resource utilization, while ensuring high quality and safety. Broad concepts of efficiency, quality and safety are used to describe the big problems of the health system, and the development of a health information technology industry is offered as the solution. Quality and safety are intimately involved in the care activities of doctors and are also the areas of greatest risk, exposure and criticism. Quality and safety also represent the areas of professional activity subject to the disciplinary techniques of metrics and accountability. The respondent is suggesting that inadequacies exist due to a lack of facilitating technologies. The response presents, as taken for granted, an explanation of preventable hospitalization as creating unnecessary demand, and the inadequacies of the health system as linked to an increase in chronic disease. A role for eHealth in merging administrative and care activities in a concept of healthcare as a risk management task is being presented. The commercial appeal of eHealth is conceived as its ability to dilute professional accountability for quality and safety and its ability to address management aims of resource utilization. The right way to practice is suggested as a team based approach, an approach which CR1 suggests is constrained by expensive communications.

6.4.5 Supporting self management

Changing understandings of the composition of quality healthcare to include the provision of information upon which the consumer/patient can react in support of self management is suggesting a role for eHealth. CR1, CR2, CR3, CR4 and MR5 indicated their understanding that eHealth had a role in supporting the consumer as a participant in their own healthcare. NEHTA’s general manager describes the benefit as a shared care plan:

When most of the clinicians and consumer groups are consulted, they see the biggest value not so much in a shared record as a shared care plan. You have a point where people can come together – this can be part of that. It’s not a passive thing it’s an active thing so everyone in the team involved in your treatment knows what the others are doing and in an informed way.
(General Manager Implementation, NEHTA, CR3)
CR3 suggests a strategy to encouraging correct usage of the care plan by focusing on the ‘plan’ and away from patient information. Issues of information ownership alluded to by an eHealth solutions provider (CR2) above:

The GP will create a summary but he’s not going to let go of everything that he’s got. He’s just not because it’s his.

And issues of privacy have focused on a patient record (NEHTA, 2011). CR3 is identifying a value proposition for eHealth as a shared plan for care which is stored centrally discouraging silos of information. Implicit in CR3’s reply are changing ideas about the central role of the doctor patient relationship and the elevation of the informed patient/provider relationship in assuming responsibility for managing health outcomes.

A role for eHealth in shaping the informed patient is suggested by the participant representing NEHTA:

[The future of eHealth] That has to do with consumer health literacy and targeting those things. One of the reasons for starting the pilot in three small sites is they have every intention of bombarding those people with all manner of media communication strategies making them aware of what’s there and what’s not. (General Manager Implementation, NEHTA, CR3)

The pilot being referred to is being run by NEHTA (2011) and is for a personally controlled electronic health record (PCEHR) system. CR3 is suggesting that to assume the role of informed patient necessary in a self management model of healthcare, patients need to be directed in their access to information in order to exploit its potential. Implicitly CR3 is suggesting that patient/consumer’s will drive demand for additional information.

Simply providing the mechanisms for accessing information as a means of bringing about a change in behavior which encourages the right choice of medical service is questioned by some participants, though more strongly amongst the medical profession. Illustrating with an example from practice which was drawn on earlier, the perverse outcomes of the changed doctor patient relationship is described:
There is technology available, there are tests available and people want certainty. I can’t tell you the number of times I have a child with a headache and the family wants an MRI, on so many levels that is not right. It takes time to convince the family it is not needed and I know in many instances clinicians will simply do the test. (Pediatric Lead, MR3)

Informed patient as demanding consumer choosing intervention over self management of risk factors is the picture painted by MR3. MR4, MA1, CR4 and MA2 also articulated a concern with patient choice for interventionist approaches and an under appreciation of own responsibility for preventative health measures. A representative from nursing administration indicates a change to expectations with respect to provision of publicly provided services is required:

We have a culture of not necessarily being able to look after ourselves. Although we’re healthy, we’re educated and we’ve got the information, we expect others to provide it. I think that is a real challenge. It’s not just about funding the service. It’s about how do we educate the population to say ‘you’ve got to take more responsibility for your own, and for your family, and for your communities health’ … we have to prepare people to be more resilient to be able to look after themselves, I think healthcare fits into that (Director Royal District Nursing Service (MA2)

MA2 is suggesting that a strategy of ‘if you build it they will come’ will fail. MA2 is identifying the problem of managing health service delivery in competitive structures as entrenched patient expectations in respect of accessing curative medicine within a universal health insurance scheme. MA2 is highlighting the significant effort required to change social values to accept a revised conception of healthcare.

6.4.6 Summary of eHealth’s role in changing the boundaries of professional activity

In summary, participants indicated that the boundaries of privatized professional healthcare activity are being reshaped to incorporate disease-focused preventative/risk management services. The dual aims of constraining costs in a publicly funded system, while transitioning from an acute model of care to a disease view of healthcare in a preventative/risk management model is supporting a view of the current system as inadequate. Opportunities for alternate possible solutions to healthcare delivery have been created to address the perceived inadequacies of the current system.
Alternate solutions include team based care, self management and information systems. The potential of these solutions to reshape expectations in a healthcare system built on competitive structures includes: steering from a distance individual responsibility for bringing about behavioral change through the auspices of health information; steering from a distance professional responsibility for bringing about practice change through the auspices of evidence, care plans and a managed knowledge base. An area of exposure is the ability to steer the ‘right’ choices – those aligned with public health principles of preventative self management of risk factors. Current institutional arrangements including the current entrenched use of information systems is constraining the potential for reform.

Respondents perceive a view of informatics as vital to quality healthcare outcomes is being formed. The contestation of the idea that efficacy data provides a picture of effective outcomes will impact upon legitimacy granted to eHealth in the discourse of quality healthcare. The potential of eHealth is being renegotiated, impacting the breadth of roles identified for eHealth by the respondents in support of the self management of health outcomes.

6.5 The New Position and Role Occupied by Health Informatics

The previous section highlighted the impact of performance outcome metrics linked to preventive measures as reshaping professional boundaries, and positioning the informed patient in assuming as demanding consumer in care decisions. This section will look at the conditions which are positioning informatics in the transformation of the discourse of health. Participants discuss the impact of a view of information as neutral which has underpinned econometrics, as having changed perceptions of quality healthcare. Participants describe a changing view of information from information as collectible to information as capable of managing quality health outcomes.

6.5.1 Perceptions of poor quality healthcare

Quality output performance metrics which include economic measures were understood by the medical respondents to be causing a perception of poor quality healthcare. MR3 provides an interpretation typical of medical respondents of the impact:
The community is very demanding - to have good outcomes, to get timely treatment, for it to be accessible and to be able to make choices. To get that, it costs a lot of money. I think there is a mismatch between what people want and what they’re prepared to give. (Pediatric lead, MR3)

The respondent interprets patient demands as unreasonable expectations of health services, while implicitly acknowledging that healthcare quality is perceived to be poor. Describing the publics demand for competitive structures such as choice in a publicly funded system, MR3 highlights that expectations are unmet. Understandings of the cost of healthcare are provided by budget cost figures. The respondent suggests that expectations can be met if a lot of money is spent. MR3 identifies the high cost of the demanded services, and the amount the community is prepared to pay as the explanation for the misalignment between patient expectations and quality delivered.

Meeting community demands from a publicly administered health system was considered an unrealistic aim by the representative of General Practitioners:

It comes back to everyone always thinks the health system can be improved, which is why people would look at it to say this doctor or that hospital is performing better than the others……. It is always going to be taken, particularly by the media as ‘now we know who is hopeless let’s get stuck into them’. Rather than now we know who is not doing as well as they could, let’s help them lift their standard. That is the problem with it. These simplistic tables don’t help, it just encourages the public to think in those sorts of terms. It’s a league table… So often it is a sort of negative feeling that you get. (CEO of General Practice Victoria, MA3)

Describing comparisons of output performance statistics, MA3 suggests they are used as judgement of ineffectiveness supporting a picture of the healthcare quality as inconsistent or poor. Explicit in the response is the view that the profession do not view quality metrics as a tool to improve practice, but as a disciplinary tool. MA3 describes the profession as under attack from the statistics and comparison which paint a negative picture of quality. Implicit in the response is the suggestion that the relatively simple symbolic representations of quality are underpinning the idea that improvement is necessary.
There was support for the view that quality output performance metrics are under representing the complexities and indeterminacies of how medical work is actually conducted from the medical respondents. The Vice President of the Doctors Reform Society⁶, a society which supports universal access to healthcare states:

A major factor impacting health status is social determinants of health and these are not measured in health outcomes. You see patients who lack resilience come into the healthcare system looking for more than it can offer. They expect useless investigations, simple answers and organic explanations from doctors. They become dissatisfied, the doctor is dissatisfied, not to mention it is a significant waste of resources.
(Vice President Doctors Reform Society MR2)

Identifying the focus of current output metrics as professional practice, MR2 describes unrealistic ill-equipped patients as contributory to creating a picture of poor quality healthcare. Calling for a broader measure of quality to include factors outside professional jurisdiction, MR2 suggests diluting explanations of causation to include patients over utilization of resources. The need for informed, responsible patients to improve perceptions of quality healthcare is implied.

Also arguing for a broader measure of quality were the medical respondents MR1, MR3, MR4 and MR5. MR1 describes quality performance output as involving professional judgment, which cannot be reduced to a quantifiable metric:

*Speaking of measuring quality healthcare* it needs to be efficient, effective, and accessible, it needs to be safe, affordable and very importantly it needs to be caring. There is a qualitative aspect of healthcare quality which is totally forgotten about often. There is an ethical and value framework around health
(Chronic Disease Director, MR1)

MR1 identifies the current view of quality as made up of administrative measures but argues that it also includes notions of professional judgement, care, ethics and values, residing under professional jurisdiction, which is not readily captured in quantitative measures. Highlighting the tension between care and administration, it is suggested they are separate aspects of

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⁶ The Doctors Reform Society (DRS) was formed in 1973 to support the proposal for a publicly-funded universal health insurance scheme, in opposition to the Australian Medical Association. The society describes itself as a medico-political think tank, a lobby group and a public resource centre. It is not affiliated with a political party. It is committed to public health care. (http://www.drs.org.au/about.htm)
healthcare. A view that ‘care’ which is within professional jurisdiction cannot be subjected to management techniques is expressed.

The profession, which is not a homogenous entity, is ‘both an institution and a conglomerate of multiple and conflicting interest groups’ (Collyer, 1994:7), holding various perspectives from advocates of public health who view being health as a right of citizenship, to entrepreneurs who see healthcare as a market place. Across the various perspectives there was agreement that the quality of healthcare is perceived by the community to be poor, and generally that this is related to patients/health consumers unrealized expectations of the healthcare system. The responses indicate that the perception created by the concept of quality which includes measures of administrative performance, and excludes measures of ‘care’, is that the current system is inadequate and change is required. In most responses the doctors interviewed recognize the requirement to defend their practice in light of costs and patient/consumer satisfaction. The responses detailed above suggest the doctors perceive themselves as subject to the administrative techniques of accountability.

MR1, MR2, MR3 and MA3 describe the misalignment between doctors and patients about what constitutes quality in healthcare (above) suggesting econometrics as contributory to this misalignment in understandings. Econometrics encourages an understanding of quality health outcomes as deliverable for the right price. Within a market society choice and quality are the competitive structures which drive the market to respond to consumer demand. Quantitative data provides for comparison of price, products and providers and is used to guide consumer choices. This same data is used as an administrative technique to apply accountability measures to providers, making providers responsible for competitive actions. Metrics which suggest the right level of resource utilization, efficient evidence based practices and effective outcomes in healthcare create the impression that quality health outcomes can be managed. The medical respondents argue that this simple view of healthcare is inaccurate. Authority to speak on the constituents of quality healthcare provides the profession with autonomy over the right way to practice (Bourdieu 1984). The medical professions claim to expert knowledge has supported the jurisdictional boundaries within which the profession has the right to speak about quality healthcare (Abbott 1988, Bourdieu 1984). A misalignment of doctor and patient understandings
of quality can therefore threaten the professions autonomy, and reshape the doctor patient relationship. Econometrics has become a point of contestation because they represent the tension between professionalism and corporatism and have the potential to impact power relations. There is a lot at stake for the profession when influencing the interpretation of econometrics.

6.5.2 Widening the interpretation of quality

Advocating the extended use of metrics to allow for a wider interpretation of quality was a strategy suggested to combat the intractable role econometrics play in monitoring quality in healthcare. Representing nursing administration, MA2 states:

I know in community health we really struggle to show the impact of the health services provided. For example there is a lot discussed about emergency departments and the reporting that they need to do, the standards they need to meet and the funding that is tied to that. We collect a lot of data about that. There is a lot of discussion surrounding that. What we’re not measuring is the interventions that are keeping people out of emergency departments and in the longer term how will we manage chronic disease and how do we measure the impact of the dollars we spend in that space. We can’t readily put our fingers on the impact of having a domiciliary nurse or having a wound clinic in the community and the impact that has on the population of health, and the dollars spent on that.
(Director Royal District Nursing Service, MA2)

MA2 identifies the current published metrics as constraining explanations of the right way to practice. MA2 suggests that acute care receives exposure due to the focus it receives from published metrics, excluding explanations of care which do not form input into metrics. Explicitly, MA2 highlights that a lack of information is influencing explanations of the right way to practice, and that this information is not as readily accessible as data supporting the acute model of care. Implicitly, MA2 suggests existing data sources constitute an institutional structure in support of the existing model of care.

The call for expanded information sources was echoed by others in the profession who suggested extending metrics of quality healthcare to include areas of Government jurisdiction as an alternative to simple metrics, ascribing informatics a role in facilitating a political exchange. Director of chronic disease at a public hospital, MR1 describes:
If you measure casemix funding for say a hospital with a large indigenous population, like Cairns, as compared to a hospital in Vaucluse, you may end up with the same number of patients coming in with pneumonia, but by golly, the resources required are totally different. We do need better ways of integrating that socio-economic information as well as the casemix type of information to reflect what the real resource needs of the population are.

(Chronic Disease Director, MR1)

Describing the simplistic focus of quantitative measures to describe quality outcomes in healthcare, MR1 suggests broadening the data sources to include socio-economic measures. Stating that lower socio economic patients consume greater resources than higher socio economic patients, MR1 describes the current system is inequitable. Equity of access is an area of Government responsibility and suggestions that current metrics do not measure it adequately were supported by other medical respondents with a public health focus:

We need to be looking beyond medical access to services to get a measure of equity, if we could get measures of the outcomes of diabetes interventions for example that might be useful.

(Vice President of the Doctors Reform Commission, MR2)

MR2 identifies the need for information to support a broader definition of healthcare including not only the biomedical explanation but also epidemiological and public health explanations. MR1 and MR2 suggest expanding quality measures of healthcare to include areas of Government responsibility in accountability measures of output, a strategy which would dilute critique of medical practices.

6.5.3 Linking access to metrics to management of quality health outcomes

Equitable access to healthcare services underpins a universal health insurance scheme and ensuring equitable access has been viewed as an area of Government responsibility. The term equitable access was mentioned by only three participants in this study, by Policy Analyst PR1, and medical respondents MR1 and MR2. All other participants emphasized a role for Government that was associated with improving or ensuring productivity measures. A General Manager from NEHTA interpreted the role of Government as providing access to healthcare information:
The Government role is to provide access to information and provide this access in two ways. One is … being able to know how to access services, that is about the degree of self empowerment. The other thing is reporting on what quality of care you’re getting from our services – so real time access to waiting times.
(General Manager Implementation, NEHTA, CR3)

CR3 describes management of healthcare delivered through quality metrics and access to information as the Government’s role, positioning informatics as the solution to management issues under Government responsibility. CR3 suggests that the Government role in the management of quality health outcomes is in promoting informatics which it regards as essential to ideas of quality. Ostensibly concerned with improving efficiency and the allocation of resources, informatics ability to contribute to an understanding of quality in healthcare is stated here as access to metrics. Ideas about consumer choice tied to patient responsibility for care are described as underpinning eHealth.

Giving access to metrics which provide an explanation of quality healthcare outcomes in terms of productivity, a description of efficiency and allocation of resources makes the necessity of informatics in healthcare appear intuitive, or commonsense. A CEO from an association representing public hospitals and community health organizations state:

Industry wide there is an acceptance that electronic platforms’ are going to be key enablers to efficiency gains and to further quality improvements. … There is that acceptance that an electronic platform is something that intuitively we believe will provide benefit.
(CEO Victorian Healthcare Association, MA4).

MA4 describes widespread acceptance of the idea of information as tied to quality through efficiency, resource allocation and reducing risk caused by uncertainty. The abilities of information systems are unquestioned. MA4 explicitly suggests that there is no resistance to the idea that future technology initiatives will improve outcomes in healthcare.
6.5.4 A role of Information Systems in quality care

The appeal of information systems was interpreted as its ability to rationally allocate resources and act as a patient surveillance technology was recognized by a CFO at a public hospital as:

I’m speaking about the non clinical systems here …..Recently we’ve seen recognition that IT and systems play a huge part in trying to deliver patient care. They contribute, not only from trying to provide an efficient and quality service, but also in the fact that the systems also assist in managing our resources. So with patient care for example we’re currently looking at an electronic obstetric information system. That’s one way, apart from having a non paper based system, that’s one way of reducing and potentially mitigating potential risk of providing care. So, as I say, there has been that real recognition. Risk and other factors play a big part in trying to deliver patient care.

(CFO Melbourne public hospital, MA5)

MA5 is describing the taken for grantedness of IT’s role in the administration of healthcare and its acceptance in the practice of patient care. Electronic obstetric information systems are modeled on existing care models and provide patient monitoring. Appreciation of a role for IT in improving the safety of existing care practices is expressed. The respondent suggests that acceptance is granted to information systems which support the acute model of care. The ability of technology to impact quality through the provision of timely and accurate information at the point of care, rather than any attempt at changing the system of professional practice is supported by the medical professionals interviewed. A typical response was provided by MR1 as:

[Benefits of eHealth to quality improvements] The patient will get good communication between their health providers. So often, if you look at emergency departments in the middle of the night, and a significant proportion (of emergency patients) are not necessarily cognitively able to handle their own information, how often are medications given in a vacuum?

(Chronic Disease Director, MR1)

MR1 describes a modest role for information systems, as filling the information gap created by patients, rather than suggesting a place for information systems in influencing decision-making about practice.
6.5.5 A role of Information Systems in the practices of delivering quality care

Those involved in promoting the deployment of information systems in healthcare also emphasized practice change at the point of care. However, a broader role for information systems was envisaged by NEHTA’s General Manager:

…the other thing with technology is the knowledge management issue and the patient safety and quality issue. If you were a clinician and you read every best practice article every day that was published you’d never treat a patient and you’d never catch up there is so much new knowledge

(General Manager Implementation, NEHTA, CR3)

The respondent describes healthcare as an information intensive service highlighting the risk of information overload to ensuring best practice patient care. CR3 suggests that best practice healthcare can only be delivered by using technology to manage the expert knowledge required for the decisions of diagnosis and treatment. The respondent expresses a view about professional and experiential knowledge as outdated and not best practice, opening space for other voices to determine what could be considered best medical practice to achieve quality health outcomes.

Setting more pedestrian expectations, CR2 who is at the cold face of deploying eHealth solutions explains that practice change will come about slowly and in small steps:

In the next 18 months there won’t be any change to clinical outcomes, maybe in the next 20 years. In the next 18 months less stupid questions will need to be asked. We expect to see someone’s HpA1c is lower because of this. We’d expect to see a decrease in adverse events due to allergies. Having access to a persons medical history can show he had a blood test last week and so I don’t need to order another one of those. That is a saving of $200 right there. I can see he is already on this medication, I can write him a prescription for that while he is here in hospital so he is consistent with that.

(eHealth and Business Development Portfolio Manager, CR2)

CR2 describes changes to practice decisions based on access to information which will result in improved safety and resource allocation, reduced cost and convenience to patients. CR2’s implies that clinical practice behaviour will change through access to information. CR2 and CR3 suggest that doctors will access information if it is provided in order to improve the care they
deliver, implying that the most efficient and effective care will be provided by doctors who access information systems. The suggested link between information access and patient safety and quality is used to heighten the perceived risks of not using information systems to improve health outcomes, risks ranging from providing care in a vacuum to out of date professional knowledge.

Jostling for a position in health discourse, understandings of the link between quality health outcomes and access to metrics is being used to secure informaticians a voice in the management of healthcare. Support for further extension of the definition of quality healthcare is coming from those with an interest in public health who are seeking to include a broader range of socioeconomic factors in explanations of illness. Econometrics which bring accountability to medical decision making, are shaping understandings of quality health outcomes as manageable. Broader socioeconomic metrics would extend accountability to areas of Government jurisdiction. Expanded definitions of health outcomes serve to support the notion that more information is necessary.

### 6.5.6 Summary of the new position and role occupied by informatics

In summary, the participants’ responses suggest ideas about quality health outcomes are being shaped through control of metrics inscribed in eHealth systems. Ideas linking information to quality through efficiency, resource allocation and reducing risk caused by uncertainty are being diffused. A concept of quality health outcomes as manageable is being shaped by the role assumed by informatics. Understood in terms of economic concepts, acceptance of a role for information in resolving management issues in healthcare has been created. There was an understanding that the professions ability to influence interpretations of the right way to practice medicine was being undermined through exclusion of information informing quality metrics. The responses suggest strategies to allow for broader explanations of causation involve expanding information sources for inclusion in metrics. An unintended consequence of this approach is that it further entrenches the idea that health outcomes can be managed through greater access to information. A role for informaticians in speaking about the right way to practice healthcare is being shaped by broadly held views of information systems as contributory
to management of safe and quality healthcare and concepts of quality health outcomes as inclusive of access to information.

### 6.6 A New Mode of Functioning of Language

The previous section highlighted the impact of econometrics on perceptions of quality health outcomes as manageable, and the positioning of informaticians in the management of healthcare. This section will focus on the way in which the categorization of disease is reshaping perceptions of disease from cure to preventative risk management, influencing the way disease is talked about. Participants describe a changing view of the problem of healthcare from professional care to management of outcomes.

#### 6.6.1 Wide categories of disease

All participants spoke of the growing problem of chronic disease. The emphasis on wide categories of disease and adoption of a disease focus were broadly understood to be taking place. That this was suggesting the problem of healthcare as a management issue rather than an issue of professional care, was expressed by CR2 as:

… we can classify people into groups – you’re diabetic, you’ve got heart disease, you’ve got …, and the other one is we’ve suddenly realized it costs a lot more to look after people who’ve got heart failure or diabetes, and someone got to the Government and said it’s costing you a whole lot to look after these, when you can spend $10,000 to get them managed. They see people at risk of readmission and they target people with chronic diseases.

(eHealth and Business Development Portfolio Manager, CR2)

The respondent describes the categorisation of disease as focusing attention on resource utilisation and suggesting the problem of healthcare as a cost management issue. CR2 explicitly states that alternatives to the acute model are positioned as more cost efficient. What is implied here is that a view of the existing acute healthcare model as inefficient has been shaped by analysis of resource utilisation data categorised by disease. The respondent suggests that management approaches are viewed as applicable in the health setting by Government.
Providing an explanation of the creation of broad categories of disease, the CEO of an association representing public hospitals and community care (MA4), suggest the reclassification of acute conditions was necessary to highlight preventable conditions. MA4 describes how reclassification allows for an assessment of quality performance which included preventable conditions.

Everything we used to call acute isn’t acute. It’s sub acute. We’re just getting better at how we express things. We used to badge things rather inappropriately. A hospital was always an acute centre. The peculiar thing is that even though we now monitor ambulatory care sensitive conditions, we still pay for them. ... So you still do get paid for have an admission that could have been preventable. We know in Victoria from the last data collected that almost 11% of admissions were ambulatory care sensitive conditions still. I think nationally it is high 9’s or 10%. That is a big issue. (CEO Victorian Healthcare Association, MA4)

A concept of disease which utilizes wide categories is redefining what had previously been considered acute problems subjecting more conditions to scrutiny within a preventative/public health principles framework. Under this framework, the central position of the hospital could be questioned. The respondent demonstrates that under such categorisation, the problem of healthcare is viewed as a management issue subject to econometrics and incentives/disincentives rather than an issue of professional care.

6.6.2 Changing the way we talk about preventative risk management

Supporting cost efficient public health preventative principles in clinical practice is the concept of disease focused chronic care models. The conceptual framework of the Chronic Care Model\(^\text{7}\) of healthcare promotes the idea that the problem of illness and health is the management of disease risk factors (APHCRI, 2010). Describing the migration from an acute system to a disease focused response, a Policy Analysts view of the Government response is:

Medibank and the systems before it were a response to a set of health problems. We are still answering the problems of a system dominated by acute health. The Government is now trying to shift that to say ‘the problems are now chronic care. How do we structure a system that will firstly prevent these problem and secondly manage chronic care rather

\(^{7}\) Various Chronic Care Models – self management support models - are in use throughout Australia: Wagner’s chronic care model combined with policy components from the World Health Organization’s Innovative Care for Chronic Conditions Framework are used in support of heart disease patients in NSW (Phillips, 2004). The Flinders Model is in use in Victoria (Victorian Department of Health 2011).
than acute? It is a very different set of health problems we’re trying to manage. We talk about prevention and management of chronic disease.

(Policy Analyst, PR1)

The respondent identifies the focus of current reforms as a reaction to changing illness profiles, the problems of the acute care model and a desire to reposition the system towards a preventative/public health model delivered through private practices. PR1 suggests that by presenting the problem of the acute care model as unsuitable to manage chronic care, an environment for change in which prevention/public health become central is being created. The language of reform being chosen was detailed as prevention and management of chronic disease. Implied is the suggestion that these changes are driving the transition of the healthcare discourse from care to management.

The categorization of chronic disease and ideas about management of chronic disease were supported by a change in research emphasis in the mid 2000’s. The Sharing Health Care Initiative Research Grants Program (DoHA 2011c) drew from a research funding pool separate to the NHMRCs. This pool of funds was coordinated by the Commonwealth Government Department of Health and Ageing. The separate funding allowed for alternate explanation of effective management of disease ‘aimed at expanding the evidence-base that suggests people who effectively manage their chronic disease enjoy a better quality of life, visit GPs less and stay out of hospital’ (DoHA, 2009). Providing the compelling evidence required by the medical profession is the intention.

Legitimate explanations of disease causation had been provided by the research funded through the NHMRC. Between 1997 and 2007 the NHMRC funded in excess of 500 genetics research projects spending approximately 242 million dollars (NHMRC 2011a). The research emphasized the link between genetics and disease risk: ‘as the focus on genetics and single genes is shifting towards multiple genes and gene-environment interactions (genomics and epigenetic), our understanding of the more complex multifactorial genetic disorders, such as cancer and diabetes, is increasing. This has resulted in a more mainstream approach to the application of genetics and genomics to a wide variety of clinical problems in the healthcare setting’ (NHMRC 2011b). The genetics explanation of disease does not apportion blame on the lifestyle choices of
the patient, instead the genetic lottery is understood to play a significant role in the health impact of lifestyle choices (Schermer, Vernon, Maio, Jang 2011:238). The patient is considered to be less in command of their behaviour, guided less by individual choice than by their genetic makeup (Schermer 2008:38). In this explanation of disease, curative therapies rather than behavioral change are offered as solutions.

The primary focus of ‘The Sharing Health Care Initiative Research Grants Program’ (established 2009), is an initiative funded by the Department of Health and Ageing (DoHA 2011c) which involves patient behavioral change and self management approaches to managing the risks or conditions of chronic disease. The research projects funded by this initiative are intended to create knowledge, and the evidence required, to support an alternate explanation of quality health outcomes as manageable through patient self management practices. Detailing the research projects funded by the program, the Department of Health and Ageing (2011c) describe: 1) the Curtin University of Technology Project: Home Heart Walk: a tool to increase exercise capacity and self-efficacy for exercise, 2) Flinders University - Human Behaviour and Health Research Unit, Project: A Randomized Control Trial of the Flinders model of self-management (recently renamed the Flinders Program) support for older Australians with complex chronic diseases, and their carers, 3) Flinders University - Human Behaviour and Health Research Unit, Project: Are patient competencies in managing chronic conditions improved using the Flinders self-management approach? 4) Monash University - Department of Epidemiology and Preventative Medicine, Project: Telephone-based delivery of care management for depression following a heart attack, 5) University of New South Wales - Centre for Clinical Governance Research in Health, Project: Evaluating the Impact of the ‘Patient-as-Professional within a Network’ Tool to Self-Manage Chronic Disease, 6) University of South Australia - School of Nursing and Midwifery, Project: People with chronic disease and the influence and impact of trial and error as a self-care strategy: a novel approach (DoHA, 2011c). All research projects funded under the program have as their aim knowledge creation in support of self management of chronic disease risk factors.
6.6.3 Changing the way preventative risk management is practiced

The professions influence in prescribing self regulation behaviors to patients provides the terrain on which Governments and the profession intersect in preventative medicine delivered in a privatized system. As a Policy Analyst explains:

The Government does have a public health agenda, in the broader sense of the word, it wants to run through private practices and so it is probably legitimate to fund that investment. That is how I interpret a lot of things. For example Government is supporting infrastructure development in a number of general practices because it wants capacity for team work and it wants capacity for clinical placements and support for chronic care models. So there are some public sector agendas to run through these private sector businesses.
(Policy Analyst, PR1)

The respondent indicates the Government’s emphasis on practices such as team work, care plans and chronic care models in order to steer from a distance the market for privatized preventative care. PR1 expresses an understanding that the incentives offered to private businesses in terms of infrastructure development brings with it anticipated return on investment in the form of public health initiatives delivered through private practice. Implicit in the response is the understanding that Governments can influence but not control implementation of reform initiatives.

Underpinning care plans and chronic care models is a disease focused view of healthcare. A number of participants – in particular MR1, MR5, MA2, MA4, CR2, CR3 and CR4 - saw self management as a positive approach to managing disease risk factors. A management program being run in Victoria which endorses such an approach was described by CR2:

[In Victoria] If you go to a hospital now and you’ve got a chronic disease you’re more likely to be enrolled in a harp (hospital admission risk program). … A case manager will talk to the GP, make sure you are exercising, visit your house to make sure you have enough rails and that kind of thing, organize meals on wheels. It is cheaper to have someone do that than have you in hospital for another two weeks. The patient is happier and healthier and all of that kind of thing.
(eHealth and Business Development Portfolio Manager, CR2)
The use of team based care models which promote a preventative self management approach to patient care is an approach taken in Victoria. Such programs support ideas of preventing hospitalization, containing cost, and demonstrating the efficacy of alternatives to the acute model of care. A view that it is in the best interest of the patients to have their disease managed as a risk management issue is expressed. An understanding that care models facilitate a shift from the central relationship of doctor/patient, to the central relationship of case manager/patient is expressed.

6.6.4 Shaping patient understandings of preventative risk management

Influencing doctors to prescribe self regulating behaviors according to a preventative/public health agenda are team based approaches, disease categorizations and care models. Patients are required to accept responsibility to manage their health. MR3, MR5, MA1, MA2 and CR4 indicated that patients’ interests need to be shaped to take responsibility for addressing behavioral issues in preference to seeking out curative measures. A director of the Royal District Nursing Service states:

We need recognition that there is a balance between how much we have to pay for our own healthcare, how much we have an obligation to prevent our health deteriorating. Apart from the policy direction there is an education side which has to ramp up quite significantly. I think in an ideal world people would make decisions about their own health, they’d stop smoking, they’d exercise more, they’d eat healthier foods, they’d lead healthier lifestyles. In reality people behave as people. You can put incentives in place, you can put penalties in place for bad behaviour, and the reality is people behave in their own self interest.

(Director Royal District Nursing Service, MA2)

Patient apathy in a publicly funded system is described as undermining attempts at reform. Suggesting is that when informed, patients will understand how to prevent aspects of illness through lifestyle choices. MA2 highlights that people may not make the right choices, the potential to nudge people in the direction of the right choices is suggested. The respondent expresses the idea that there is unnecessary demand for curative services, and that individuals who take responsibility for behavioral change will remove the demand. Ideas about the link between illness and lifestyle choices, the identifiably wrong lifestyle choices and the impact of behavioral change on illness were expressed.
Access to information systems which steer the health consumer towards self management approaches was suggested as a means of encouraging a change of behaviour in patients. The President of the Health Informatics College explains:

> The ideal system is where the patient has primary fundamental access to the knowledge and resources that allows them to make the decisions about their care process in conjunction with their clinical decision maker. Patient centric. If the patient doesn’t own the responsibility of the decision making, nothing is going to work anyway. Patient and primary care is where we need to deliver effective, timely reliable complete information. This doesn’t cut the clinicians out of the system, we’re the ones providing the filters for that information going to them.  
> (Clinician and President of the Health Informatics College, MR5)

Steering choices of risk management measures is the area of struggle in a competitive market space. MR5, who is also a clinician, encourages the positioning of the clinician as the filter for information. Information which facilitates patient decision make could support a view of self management of risk factors as providing quality health outcomes, or it could support a view of curative interventions which require limited behavioral change as providing quality health outcomes. Authority to speak on the cause of illness suggests possible solutions to managing the risk of illness which can favor either public health cost contained options or the status quo in a fee-for-service model. The respondent expresses a view of the medical profession as custodians of expert knowledge and as a central figure in patient decision making.

Scepticism about the potential of eHealth to create informed patients was expressed by MR1, MR4, MA1 and MA3. CEO of General Practice Division highlights consumer apathy and poor quality information as the problem, commenting:

> Whether technology will change the way in which people do things, well, it might by giving patients more information. That tends to assume that all the patients are people who are interested in getting more information. I just don’t think that is the case to be honest. In spite of all the talk about the internet and you can find out this and you can find out that, the majority of people don’t. They just don’t. Maybe that is because a lot of the information you get off the internet is pretty much rubbish, and maybe if there was a source of good information maybe more people would use it. That would be a change to relationships between doctors and patients, if you actually had sources of information that were reliable.  
> (CEO General Practice Division, MA3)
The distance between the potential of eHealth to enable informed patients and the level of health literacy being actively pursued by patients is described. Pointing to the poor quality of information available to patients via the internet, the respondent suggests that quality information could encourage patients to become informed patients. A view that informed patients will reshape the doctor patient relationship is expressed. The response implies that good information sources can be identified and managed.

6.6.4 Reshaping institutional structures

The ability to constrain alternative explanations for how to manage risk factors when commercial interests are present was suggested as a constraint to the possibilities of eHealth. With twenty years experience working in the health sector, the CEO of an association which represents hospitals and community health implies change will only take place where there is political will:

There is potential for electronics to play a role in preventative. It is limited to what are the flags what are the parameters and setting those sorts of things in place ... If there is some way in which these things can be delivered on consumer platforms, it could be a way to transform health, but political will is the biggest issue really. The tobacco lobby and the way they protect their right to sell tobacco advertising, our reluctance to label alcohol as dangerous is one of those political issues that needs to be dealt with. The food labelling debates that we’ve had for the last decade and the push back from the fast food industry. That is political will: I don’t think eHealth is going to make any difference at all.
(CEO Victorian Healthcare Association, MA4)

The respondent highlights the difficulty in bringing about practice change while supporting competitive structures: asking patients on the one hand to take responsibility for their risk behaviour while supporting curative approaches which market a quick fix. MA4 describes the difficulty in convincing patients to avoid consuming products that are available freely in the marketplace. The respondent perceives a lack of political will for genuine transformation of institutional structures, which will limit transformative change. MA4 suggests that eHealth initiatives which are aimed at providing patient services with respect to preventative risk management care have the potential to stimulate change, but are unlikely to impact current institutional arrangements. The implication of the response is that the current institutional arrangement supporting an acute curative model of healthcare will not be disrupted by eHealth because the political will does not exist.
6.6.6 Summary of health as a risk management issue

In summary, a disease focused view of healthcare which utilizes broad categorizations of disease in a preventative/risk management model employs the language of management to describe health outcomes as self manageable. A view that it is in the best interest of the patients to have their disease managed as a risk management issue is being formed. Explanations of disease causation provide understanding of disease risk factors. The risk management view of health obliges the patient to manage risk factors. In support of a self management approach to preventative care, lifestyle behavioral choices determine the risk factors to be managed. A genetic explanation of disease suggests personal genetic predisposition determines the risk factors to be managed. Research efforts provide explanations of disease which suggest the effective methods for managing risk factors. Explanations favored by health consumers/patients reinforce the inscribed authority, and provide the market for possible solutions. Consumers/patients are directed towards their choice by the information funneled through the practitioner. Without political will, institutional arrangements in healthcare will be difficult to reshape. Care models and informed patients have the potential to influence the central position of the doctor patient relationship. Participants suggest patient apathy towards their health needs to be addressed to encourage health literacy and risk management behavior.

6.7 A New Form of Localization and Circulation of Discourse

The previous section highlighted the way in which the categorization of disease is reshaping perceptions of disease from cure to preventative risk management, influencing the way disease is talked about as self manageable. This section will describe the impact of a team based approach to providing healthcare services to the ways in which health discourse is formulated, amassed, conserved or contested. Participants describe the skills based approach to medicine and the establishment of Medicare Locals (2011)\(^8\) as meeting the dual aims of allowing the Governments to retreat from direct service delivery of public health initiatives while promoting manageable competitive structures for the delivery of preventative healthcare and acute healthcare within one

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\(^8\) Medicare Locals were established on July 1\(^{st}\) 2011. They are a national network of primary health care organizations set up as an independent legal entity. They assume a role in identifying gaps in the current healthcare system and consolidating relationships with hospitals, community health, private providers and aged care. (http://medicarelocal.com.au/about)
system. Participants describe multidisciplinary teams are creating demand for information sharing.

6.7.1 Team based approach to delivering health services

A disease focused risk management view of healthcare, which conceptualises wide categories of disease such as chronic disease as complex and requiring various expertise to manage supports the principles of the community health program of the 1970’s. The Community Health Program of the 1970’s established an infrastructure of multidisciplinary health centers, employing salaried professionals, providing curative and preventative health in defined geographical areas. In the 1970’s the preventative focus and the community health model was subsumed by the larger structural concerns for equitable access to curative services through a universal insurance scheme. Much of the focus was on access to hospital care. The focus in the current proposal, Medicare Locals, is on team based care with the doctor as the central player. General Practice Divisions will be replaced by Medicare Locals. The CEO of General Practice Division describes the reform:

The thing that caused community health to fail in the Whitlam era was that doctors refused to be involved. Well, this time, they’ve got a program, the divisions’ programs objectives are very similar to the community health program, the difference is they’ve hung it all on the doctors as the vehicle to make it work. The doctors aren’t withdrawing from it because the program is actually them. If you thought that way, you could describe that as a master stroke, I think it was serendipity. That’s why it might actually work because the doctors are keen to be involved now.

(CEO General Practice Division, MA3)

The divisions of general practice were established to bring public health principles to general practice, while acting as a representative body for general practitioners where participation by doctors was entirely voluntary. The divisions are doctor organisations. (CEO General Practice Division, MA3). The establishment of the divisions’ programs was first outlined in the 1992 Budget Related Paper No.8 circulated by the Commonwealth:

funding of $17 million to encourage general practitioners to broaden their role beyond the level of individual patient care … to support the establishment of local ‘Divisions’ of general practice which will supply a focus for the professional life of GPs, enable general practice to be better integrated with other aspects of the health system and provide a
mechanism for general practitioners to become involved in local area health planning and priority setting.  
(Howe, 1992)

The CEO General Practice Division (MA3) describes current reform efforts as continuing the diffusion of ideas first attempted in the 1970’s, this time recognising the need for doctors’ support to make community health a reality. The respondent describes the reinforcement of a central position for doctors in the delivery of healthcare as supporting their participation in Medicare Locals. Implied is the futility of reforms to healthcare which deny the doctor a central role.

The support given to existing institutional arrangements by Medicare Locals, which have been referred to as ‘GP’s with add ons’, was questioned by a Director of Royal District Nursing Service:

Medicare Locals will be an interesting development because the idea of that is you’ve got a center in primary health care that will act as a focus for delivering all sorts of service and that will enable collaboration of different types of providers. Are we going to do that in a structure where they become part of the one entity, or do they come and go and it becomes a focus for the service delivery, and interaction with the hospitals? They are very GP focussed, they are thought about as GP with add ons rather than community health.  
(Director Royal District Nursing Service, MA2)

The respondent is sceptical about realising inclusive primary care delivered through the traditional hierarchy. MA2 highlights the confusion that exists with a model which aims to bring together a number of autonomous private service providers under one entity without a common understanding of community health. The response suggests that public health principles are not recognised as underpinning Medicare Locals.

6.7.2 Reconceptualising expert knowledge through a skills based approach

Medicare Locals have dual aims of allowing the Governments to retreat from direct service delivery of public health initiatives while promoting manageable competitive structures for the delivery of public healthcare and acute healthcare within one system. Medicare Locals, as
independent legal entities, are being positioned to take responsibility for population health planning, providing support to primary health care professionals, involving consumer groups, and for integrating multi-disciplinary models of care (DoHA, 2011). MA2’s skepticism about the community health ideals of Medical Locals was shared by a Policy Analyst who questioned the migration to a skills based approach to the health workforce which is underpinning the notion of multi disciplinary models of care.

There is a whole push to centralise and reconceptualise who does what in health, words like workforce substitute come up a lot: new professions like physician assistance, an in between a nurse and a doctor. The professions, the AMA, are very threatened by this. What the AMA is now seeing is that pharmacists are now taking a piece of their work here and others are taking a piece there – and now physician assistant is coming in. A whole professional structure of health is in upheaval. The traditional professional concepts are eroded and you have a skills based approach to the workforce.

(Policy Analyst/author, PA1)

The respondent describes the commandeering of professional medical authority by other health professionals, redefining the practice of medicine to a skills based approach to care. The demise of professionalism as a governance mode is suggested. PA1 paints a picture of a sector in transition and the profession as weakened.

6.7.3 Maintaining the status quo

The skills based approach to healthcare was advocated by the productivity commissions National Competition Policy review in 2005 which called for competitive structures to be introduced into Australia’s health workforce. Identifying the problem of healthcare delivery as shortages of specialist, the health workforce review presented task substitution as a means of efficiently allocating scare resources in healthcare (Productivity Commission, 2005b). The review cited a submission by the Australian Health Ministers’ Advisory Council (AHMAC) which noted that:

Improving health [though investment in disease prevention] has the potential to reduce demand for health services and hence reduce the need for more highly skilled health professionals.
(sub. 166: 29)
This has been translated to multidisciplinary teams, which are understood by a Primary Healthcare Liaison as:

The rise in the multidisciplinary team approach, particularly if you look at the nurse in the practice, a lot of that is around sharing the expertise so the GP can get to more of the medical stuff and the nurse can take care of the education for example (Primary Healthcare Liaison, MA1)

The skills based approach to multidisciplinary teams is not viewed by MA1 as changing professional acute care. The respondent suggests that the transfer of public health tasks and responsibilities to privatised medical practices under Medicare Locals will be delegated to allied health professionals and nurses. Suggesting the status quo will remain, MA1 interprets the skills based approach as relieving doctors of tasks which distract them from acute care. Rather than realising integrated multidisciplinary care models, a cohabitation of care models is expected. Implicit in the response is the perception that the two system approach to the delivery of healthcare, preventative and curative, will continue to exist, however, delivered though one entity.

An approach which would see nurses and allied health professionals adopt public health principles, while allowing doctors to continue their acute care focus, was endorsed by a Policy Analyst who recognised that not all illness is preventable:

When you have the nurse and other allied health professionals structured around prevention and the GP available for acute that would work … It is suffering from another problem – you set up those things when there is market failure. But there is not market failure, you already have the example of a number of private practices which do this. There are those that argue why you need the Government to do this. (Policy Analyst/author PA1)

The migration to Medicare Locals, which aims to integrate multi-disciplinary models of care, has not been fully explained. The respondent suggests that a number of privately run practices have developed markets for preventative care utilising multi-disciplinary teams. The respondent perceives an attempt by the Government to create a role for itself in steering the practice of service delivery through private businesses.
6.7.4 Information sharing in team based approach

Multidisciplinary care models and population health needs analysis encouraged by Medicare Locals require doctors to share patient information. A Director of Chronic Disease describes how this would work in practice:

Past history, previous investigations, medication history is available to all care providers to all those making decision – this information would be owned by the doctor. The Government needs to support that ownership. There needs to be rules put in place regarding privacy and confidentiality – if you have a repository of data available to healthcare professionals, they’re governed by a whole set of ethical standards, medical board standards and so on. Barriers should exist to stop non clinical people looking at the data, but once you’re a member of a clinical team then the barriers should be dropped. (Director General Medicine and Chronic Diseases, MR4)

The respondent indicates reluctance to simply handing over information about patients. Suggesting the need for professional codes of ethics and oversight by professional bodies, MR4 is making a case for professionalism by promoting the legitimizing structures of the medical profession deployed in support of exiting institutional arrangements. Explicitly, MR4 suggests that information about care practices should be retained by the profession, securing the right to speak about care practice. MR4 indicates that Government support for information flows controlled by doctors was a necessary precondition to sharing information within multidisciplinary teams. Membership to the clinical team is suggested as a role for the medical profession. Patient information as a site of political contestation is implied.

Alternate explanations for the resistance to information sharing in multi-disciplinary teams described the increasing value of patient information and its commercial appeal as the deterrent to sharing information. A CEO of a General Practice Division describes:

Part of the anxiety from the profession comes from a belief that is quite pervasive that there is money to be made from ownership of patient data. So consequently we shouldn’t give it to anyone because there is money to be made from selling it. There are people who hold that view quite strongly in general practice - that we shouldn’t just hand over this information for useful purposes we should be able to sell it because it’s ours. Patients might disagree but they don’t because they don’t really think about it very much. The commercial reality is part of it. (CEO General Practice Division, MA3)
The respondent suggests that the two system approach to healthcare delivery in which the principles of public health are not diffused into clinical practice will not encourage the information sharing. Expressed is an understanding that views of patient information ownership are tied to views of healthcare as either a public good or a private commodity.

The skepticism expressed by MA2, PR1, CR1 and MR5 that an integrated multi-disciplinary care model will result, was understood by a participant involved in the deployment of eHealth solutions as having a structural cause:

Ideally we’re all using a very flexible open source vendor – the council, the GP, the hospital, one system with one bucket of information with the right and relevant view of the right and relevant person. We talk about integration of systems but the reality is all we’re exchanging is a bit of demographic information. When it comes to clinical information, the silo’s still exist. The classic situation is the system we’re putting together we’re talking about well ‘what’s the standard for medication or diagnosis’, the hospital’s using SNOMED or ICD10 to list for their clinical coding, the GP’s got a list that just happens to be in his medical software, the guy in chronic disease he’s got another one, it sort of comes back to standards. … In terms of consent and access and those sorts of things, it’s a dog’s breakfast at the moment.

(eHealth and Business Development Portfolio Manager, CR2)

The two systems approach to healthcare is supported by existing information systems which constrain attempts to gain an integrated view of healthcare. Drawing on standards used by the various medical professional groups, CR2 suggests that systemized information structures support the existing institutional arrangements. The respondent describes the level of sharing as being at the basic level of demographic information, information sharing about care practice is not happening. Implied is that an integrated system will only be achieved when political will to bring about institutional change is displayed.

6.7.5 Information to regulate the healthcare market

Medicare locals will implement public health principles in a privatised business model. The incentive this introduces was questioned by the CEO of the Victorian Healthcare Association:

Their fundamental is co-ordination of service delivery or identifying mechanisms to improve that or population health based needs analysis and gap analysis. If you have that as a responsibility, then you shouldn’t also then take money to deliver to that because you
create an internal conflict straight away. All of a sudden what you can be seduced into doing is building your own business constantly. … Philanthropy and medicine left us back in the ‘70’s. While some Governments seem to think we can somehow reinstall that as a premise, it is a fairly nonsensical approach to take.

(CEO Victorian Healthcare Association, MA4)

MA4 indicates the difficulty envisaged in managing privatised businesses which are tasked with identifying ‘potential markets’ for publicly funded goods. The respondent states that the ideas which underpinned the community health model of the 1970’s cannot be diffused into private corporative businesses. What is suggested by the response is that ideas about healthcare as a public good are incompatible with ideas of healthcare as a competitive good. MA4 is highlighting the incompatible policy goals of Medicare locals which aim to treat healthcare as a competitive good encouraging the search for new markets, under the rubric of public good principles of community healthcare.

The potential for information to influence practice was recognised as its ability to target services. The CEO of a General Practice division identifies the use of information about the geographic base of broad categories of disease as allowing private practices to respond to demand:

The commercial reality is part of it. I think that is changing, the more they see the value of aggregated information on a geographic basic the more they will use it. Now they see how many diabetes patients live in their region, which practices are successful and managing these patients, they see the value in that kind of information. You can’t run Medicare locals without the data, you can’t plan.

(CEO General Practice divisions, MA3)

What is suggested here is that Medicare Locals will encourage doctors to provide data necessary for planning by supporting the prospect of building their businesses. The central role doctors’ play in supplying information that is imperative for the administration of healthcare is described. The Government’s right to speak on the right way to practice healthcare is dependent on the profession supplying data.

MA3 and MA4 are explicitly suggesting that having assumed a role in support for competitive structures, the Government must accept that delivery of public goods through private structures
will involve profit making behaviour. Medicare locals per se are not seen as promoting this behaviour, it is suggested by MA4 that this is the reality of a market society:

Medicare locals won’t contribute at all to the corporatisation of medicine that is just going to be a mechanism of the market and a mechanism of the profession in terms of new graduates who don’t want to be philanthropists they just want to be business people who just happen to have the business of medicine.

(CEO Victorian Healthcare Association, MA4)

The respondent describes changing professional aspirations in a market society as driving the profit making behavior in healthcare. The unalterable direction of healthcare towards a marketable competitive service is expressed.

6.7.6 **Summary specialist teams in providing care**

In summary, providing the infrastructure to support integrated multidisciplinary care models will not change the location, type or number of dissemination sites for information which informs patients’ views on patient care. Existing institutional arrangements do not support sharing of information. The public health principles which would influence doctors to view healthcare from a public health perspective, ideas stemming from an epidemiological and populations based approach, as disease focussed and involving patient self management of risk factors delivered through multi-disciplinary teams, have not been diffused into practice. The multidisciplinary teams based approach to delivering healthcare as a public good inscribed with public health principles, delivered through privatized business, is being interpreted as a skills based approach. The suggested implementation would support the existing two systems approach to delivery of healthcare. Scepticism about the Government’s interest in creating a role for itself in steering the practice of service delivery through private businesses exists. Professional structures such as ethics and information standards were cited as structures which support existing institutional arrangements favoring a two systems approach to healthcare. Patient information was demonstrated to be a site of political contestation.
6.8 The Current Discursive Formation of Healthcare

To this point in the chapter the transformation of the discursive formation since the tabling of the Health On Line report in 1997 to the present, the point of transition from policy to practice, has been examined. The boundaries of privatized professional healthcare activity are being reshaped to incorporate disease focused preventative/risk management services. An environment in which the current system of healthcare is considered inadequate has been created by quality output performance metrics linked to preventive measures. Current institutional arrangements including the current use of information systems are constraining the potential of solutions which propose to address these inadequacies. It has been suggested that the diffusion of ideas about healthcare as a public good are incompatible with ideas of healthcare as a competitive good, impacting upon attempts to impose a community health model on private businesses. The incompatibility of views of healthcare as a competitive good and as a public good leads to incompatible policy goals impacting on the dual policy approach to managing healthcare as a public good accessible to all in the form of a universal health insurance scheme, and as a competitive good subject to profit maximising behaviour and market governance mechanisms of competition based on comparison, quality and accountability.

The idea of information as tied to quality through efficiency and resource allocation which underpinned Casemix has been expanded to include reducing risk caused by uncertainty. Control of the metrics used to provide explanations of quality in healthcare applies administrative disciplinary techniques to professional practice. The professions ability to influence interpretations of the right way to practice medicine is being undermined through exclusion of information informing quality metrics. Broad categorizations of diseases are allowing the problem of healthcare to be expressed in clearly defined terms of percentage of preventable hospitalizations, changing explanations of long waiting lists from under funding to over servicing or over utilization. The idea that healthcare can be managed through greater access to information is being supported by calls to increase the information sources drawn on by metrics. Existing institutional arrangements do not support sharing of information. Professional structures such as ethics and information standards were cited as structures which support existing institutional arrangements favoring a two systems approach to healthcare. Ownership of
patient information was demonstrated to be a site of political contestation. The potential of eHealth is being renegotiated, impacting the breath of roles proposed for eHealth.

6.9 The Content of Change – The Lasting Impact of Reform Attempts

Expanding the scope for Government involvement from a role as responsible funder to providing explanations of individual responsibility in health determinates is at stake in the current reform process. The idea at the core of shared responsibility for healthcare problems in the 1970’s, was that health involves a network of relationships. Throughout the 1990’s and 2000’s this idea has been reshaped to suggest individual responsibility for health and wellbeing. The choice of measures of socio economic and risk factors in explanations of the problem of healthcare are influenced by the dominant economic order, and reflect views on which combination of factors contribute to poor health (Lynch and Kaplan, 2000). Directing health research efforts will influence which explanations of causation become accepted, and which treatments are offered as solutions. Distributing responsibility for managing risks to individuals would serve the objective of apportioning blame towards demand for avoidable (non essential) treatment, implying new ways of funding healthcare. Simultaneously, it contributes to the creation of markets which service personalized preventative risk management approaches.

The methodological foundations for analysis informed by concepts of efficiency and resource utilization drawn on from economic theory are applied to metrics which provide interpretations of quality healthcare as tied to efficiency of resource utilization. These interpretations are reshaping understandings of quality healthcare to view it as a management issue. The focus of current output metrics on professional practice, concentrating on administrative measure, incorporates readily collectible quantitative measures from infrastructure which supports the creation of such measures utilizing standard nomenclatures and understandings of terms such as throughput, to the exclusion of metrics which are not readily captured. Difficult concepts such as care, patient preparedness for self responsibility, patient capabilities for self management, are not captured. This creates a view of quality healthcare which is facilitating a perceived shift from professionalism and notions of care, ethics and confidentiality. Conceptualizations of the problem of quality healthcare as a technical issue of managing preventable risk factors are being
underpinned by health informatics. Ideas about information shaped during earlier reforms, suggest medical information as positive fact and as vital in the management of healthcare. The role of informatics is being extended to conceive of information as vital to quality outcomes in healthcare. This role for informatics supports a new role for Government in healthcare, from ensuring equitable access to managing and supporting productivity of the health workforce and beyond.

The potential of informatics lies in its ability to enact a political exchange from the dominance of professionalism and explanations of health and illness which favour the acute model of care, to corporatism and explanations of health and illness which include cost effective preventative approaches. The approach endorsed in current reforms is to elevate a broader vision for public health while working within the institutional structures which support the existing relationships. At stake is the right to influence explanations of causation and treatment. The personally controlled patient record, which acknowledges the doctor patient relationship and avoids directly challenging notions of confidentiality and privacy, is an example of the current approach to reform. Migrating from the dual privatized curative and public preventative systems, to a single system for the delivery of healthcare, while supporting competitive structures, has required ideas about equitable access to healthcare services to be reshaped. Changing understandings of the Government’s responsibility in delivering equitable access to healthcare services are ideas about information as vital to safe quality healthcare: ideas which support a concept of equity as access to health information to manage disease and risk.

6.9.1 Rules impacting the discursive dialogue

Assuming a continued responsibility in the delivery of equitable access to healthcare services, while providing for private enterprises to access public funds in the fee-for-service model, the Government’s strategy for the management of healthcare involves a concept of disease as an issue of self management of risk factors which encourages resource utilization restraint. Preventive medicine under competitive structures has been reconstituted from its role in quarantine and immunization to include identification, classification and treatment of ‘risk factors’. Under this definition, the collective nature of disease is recognized, but responsibility for acting against disease is placed with the individual patient. The individual can choose
behavioral self governance, or can access curative therapies. Resource utilization issues that occur in healthcare can be translated as patient over utilization, suggesting the possible solution of patients modifying their behavior. Supporting notions of the manageability of a competitive market for preventative medicine are ideas about quality healthcare as measurable by the number of preventable hospitalizations and adverse events. Application of information systems in healthcare in support of the quality healthcare is made possible by ideas about healthcare as manageable through greater access to information. The idea that a competitive market for preventative medicine is manageable through greater access to information is driving the eHealth reform agenda, despite institutional arrangements which will make information sharing difficult. Respondents described the entrenched application of technology in support of service delivery in a curative medicine model and the use of a variety of medical nomenclatures making it difficult to define a common structure for shared data as constraining attempts to expand data points. Also evidenced was the link between professional ownership of information and authority to speak about what constitutes quality healthcare.

Measurable outputs provide a measure of effectiveness (positive facts are measured by numbers), preventing illness involves managing lifestyle risk factors, more information will make healthcare a manageable service are utterance recognized as valid. Information systems as a vital component to managing quality healthcare, and the problem of healthcare as a management issue was suggested as statements seeking validity. The profession expressed acceptance of information systems linked to quality healthcare through improved efficiency and safety. A defined role for information systems in addressing patient information gaps, while placing information ownership with the professional was discussed. Continuing to suggest a central role for the medical profession and the biomedical approach, a single system for healthcare delivery which focuses on preventative services will subject the profession to corporatist control mechanisms of quality and performance metrics. Information ownership will maintain the mutually interdependent relationship between the profession and the Government in a single system for health care delivery. The power to document and shape understandings of healthcare involves a negotiation between both parties, maintaining the status quo. The potential for the profession to increase their political economy exists through information ownership under a concept of healthcare as an information service.
As an information service, the management of healthcare is seen as best delivered utilizing national broadband infrastructure (NBN) controlled by the Commonwealth. A legitimate role for the Commonwealth in determining the preventative agenda has existed since Cumpston first advocated a public health approach in the 1920’s. Notions of healthcare as an economic good, and the problem of healthcare as a technical issue of resource allocation were formed in earlier reform periods and are now diffused. Claiming expert knowledge in econometrics, information management and corporatist governance techniques such as accountability, the Commonwealth’s has been granted a legitimate role in management. As the problem of quality healthcare is being redefined as a management issue of systemizing information, the Commonwealth is positioning itself to assume a role in setting the direction of quality healthcare.

### 6.9.2 Rules which ensure that to practice is simultaneously discursive and material

Acceptance of the idea that clinical outcomes can be managed and that information can facilitate the management of clinical outcomes is evident. Notions of accountability as necessary and as beyond compliance to encompass performance and effectiveness were diffused in the 1990’s. Enhancing these notions, accountable to outcome measures framed within a financial management framework has expanded areas of professional practice responsibility. The idea that the medical profession is answerable to a notion of acceptable performance which constitutes preventative approaches has been diffused. Subject to administrative techniques such as care plans, the clinical examination has been characterized as a technical set of procedures, undermining the need for specialist interpretation of individual cases and setting the scene for increased self management in healthcare. Supporting self management is the promise of information systems to elevate the status of patient in the health system by providing the patient with information to knowledgeably participate in their own care, and information to judge the performance of key players. The information provided to patients will be controlled by the performance metrics used in healthcare and generated from research efforts into the causation of illness and possible treatments.
Quantifiable metrics for measuring quality have taken the form of adverse events which stem from medical treatment. Reporting of adverse events poses a concern over whether doctors should be blamed or held responsible for their work practice errors:

Potential adverse consequences of public reporting in terms of the behaviors and practices of health care providers, as identified by Scott and Ward (2006), may include: gaming, early discharge, avoidance of high risk patients, out-sourcing of high risk patients, adoption of defensive medicine, withdrawal or disengagement, and tunnel vision. The adoption of such behaviors could lead to an inappropriate shift in focus from the needs of patients to meeting reporting requirements. (AIHW, 2009)

The stigmatization of doctors who are found responsible for errors that cause harm is evident from many high profile cases which attract media attention. Reputations and the potential of loss of practicing license lead to under-reporting of adverse events (White, 2006). Accountability and its call for transparent processes suggest that errors are foreseeable and preventable, further suggesting that only irresponsible doctors allow errors to happen, and such irresponsibility should be punishable. Work which involves human interaction can be judged to be error prone when the basis of action is dependant on human opinion rather than objective evidence, as is often the case in medicine. The need to remain silent about the fallibility of doctors and medical treatment has left the profession unsure of how to claim authority over quality when current metrics call practice into doubt. The expanded realm of performance introduces a new regulative structure: the focus is on the re-forming of relationships and subjectivities causing a re-evaluation of what is considered valuable in practice.

As an information service, custodianship of health data has become increasingly important. Custodianship confers authority to speak on the causes of disease, possible treatments and importantly the ‘right’ way to practice. Power and status are contingent on authority to speak, a process of strategic responses to maintain the status quo is the response when it is threatened (Foucault 1984, Bourdieu 1988). Suggesting the inadequacy of the current system to deal adequately with contemporary health issues such as chronic disease, and safety issues in the delivery of care, undermines the authority of professionals in curative medicine to speak about quality healthcare. Also impacting upon the professions autonomy are the ideas which underpin multidisciplinary teams relating to shared responsibility in determining the cause and solution of
illness. A strategy which maintains the status quo is information ownership supported by notions of the discrete ethical medical professional entrusted with confidential personal patient information. A desire to use information ownership as a disciplinary strategy to maintain the status quo has been expressed. The two forms of power that form the basis of the position of the clinician – expert power and institutional power – can be bolstered by information ownership. A redefinition of medicine as an information service requires patients to have faith in the technical knowledge of informatics and to share information, yet privacy arrangements continue to view the basis for the medical relationship as trust in the doctor supporting the professions claims to information custodianship. The performative worth of this trusted relationship is being judged by politically constructed metrics, in a neoliberal environment these metrics are in support of management practices and it is their disciplinary impact which ensures alignment between professional and corporate goals. Currently a self conscious tug of war between institutionalized support for information custodianship and a desire to define health as a manageable information service is providing privacy its pivotal position in the discourse of electronic health records.

6.9.3 Rules establishing the limits and forms of appropriation of discourse

The problem of quality healthcare conceived as a management issue of mitigating risk factors and allocating resources has suggested the applicability of econometrics in managing healthcare. Econometrics can place ‘resource utilisation’ and ‘over servicing/over utilisation’ as the focus of causation in explanations of escalating expenditure costs. Accountable to econometrics, practice behaviour can be steered from a distance. The ability to determine the scope of econometrics used in measuring quality in healthcare currently resides with the Governments claim to administrative expertise. The struggle between the profession and the Government for the right to determine the scope of econometrics is conducted through claims to information. Contesting the validity/adequacy of information drawn on to construct measures of quality in healthcare is a tactic used to undermine the Government’s right to speak about quality. Constrained by competitive structures which impact upon the ability to escape scrutiny from metrics, strategies to maintain the status quo which call for more information to broaden the focus of causation are evident. A notion of the ethical doctor supports information ownership claims which underpin the doctor-patient relationship. Professional structures such as ethics and information standards
as structures which support existing institutional arrangements are preserving the professions right to speak on quality healthcare.

As a management issue, the act of practicing medicine is subject to managerial disciplinary techniques. The introduction of chronic disease care plans has secured for the Government a voice in determining the right way to manage chronic disease. The act of preparing the plan subjects the profession to managerial techniques, changing the nature of medical collegial relationships. The Commonwealth’s sphere of influence has expanded from the right to fund healthcare to the right to determine preventative management risk factors through care plans. Under a preventative framework, the potential for disciplinary techniques to be applied to risk factors categorized as preventable exists through standards which emphasis a norm. Evidence produced to support the norm is considered as positive fact through the use of the quantitative research approaches favored in health and biomedical research. Ideas about information as out there, as collectable and as capable of providing a neutral empirical scientific explanation of the standard are underpinning a role for health informatics in categorization of disease, determining metrics, creating disease specific patient plans. Patient plans, disease categories and standardized metrics, are contributing to an understanding of healthcare as an information service. Utilizing information systems in setting standards and measuring deviations from the norm, and applying these measures to individuals, were described as roles for information systems in support of the disease focused preventative approach. The dual potential of information systems as a rational tool for supporting self management of disease risk factors and containing resource utilization, and its potential as a surveillance tool applied against the populous exists within these proposed roles.

6.9.4 Limiting and forming the sayable in discourse – framing the problem of healthcare

The concept of healthcare as a service concerned with mitigating the risk of disease specific preventable symptoms involving advice and interventions that act as a disciplining technology influencing lifestyle choices is being disseminated. Encouraging self management of health risk factors is a demand side strategy in containing the costs of a universal health insurance scheme by reducing resource utilization. Simultaneously supply side cost reduction strategies are constrained by a continuing responsibility to support the competitive structures which encourage
the creation of a market for preventative services and the continued reliance on the fee-for-service model to support the acute model. Providing evidence of efficacy in support of a risk management view is complicated by the commercial realities of the existing delivery structures. Set against the commercial attractiveness and integration of the biomedical alternatives, the multitude of data sources which a self management approach to healthcare calls upon, the coordination of various players, the coordination of the data, and a competitive research environment make constructing a compelling case for self management of risk factors difficult.

The two system approach to healthcare has centered on ideas of disease as curable on the one hand and disease as preventable on the other, constraining other interpretations of disease and explanations of disease causation. In both instances disease is understood to be manageable. The curative approach to disease provides various explanations for causation, focusing on the body while suggesting limitations to self management and favoring intervention. The curative approach submits patients to the medical gaze and interventionist technique. The preventative approach to disease favors broad categories of disease and specifically the categorization of risk factors which contribute to the onset of disease – obesity, alcohol abuse, smoking, stress – which describe undesirable lifestyle choices to be managed. The principles of a preventative/public health agenda driven through privatized business which have been built on a curative model, requires doctors to prescribe self regulating behaviors. The focus becomes caring for the body, causing us to rethink our relationship with our body and obliging us to submit to administrative techniques such as the BMI in assessing our body against a standard. Submitting to these administrative techniques, we contribute to the validation of the concept of health as an information system.

Tied to quality through efficiency, resource utilization and reducing risk caused by uncertainty, the systemization of information in healthcare is conceived as right and necessarily capable of improving outcomes. An expanded role for information systems in healthcare beyond administration is perceived to be the right thing to do. The problem of quality healthcare is being understood as a management issue of systemizing information. Framed in this way, greater access to information is proposed as a possible solution to the problem of delivering equitable healthcare. It is no longer possible to say information management in healthcare is not an issue.
All respondents identified a need for eHealth, and improved information management practices. The data has suggested informaticians are claiming the right to speak on the right way to practice healthcare. As a management issue of information management, patient privacy has become a technical issue of information privacy protection. Patient privacy as central to the institutional structures supporting professionalism has become a contested area of information ownership.

6.9.5 The rules limiting and forming conservation of discourse

The problem of privacy of patient data framed as a technical issue of managing information access underpins the personally controlled electronic patient record. The stigmatization which certain illnesses attract continues to exist. The right to speak about causation of disease provides the ability to stigmatize lifestyle behavioral choices. A view of health information as intimate and linked to private personal information will be supported by judgment applied to lifestyle behaviors. The self management of preventative risk factors approach to healthcare supports explanations of causation as lifestyle choices. The risk of stigmatization – e.g. drug/alcohol use, sexually transmitted disease, mental health issues - will encourage those who violate guidelines for the ‘right’ behaviour to seek out the confidential professional relationship, supporting the professions claim to information ownership and the doctor patient relationship.

Ideas about a nationalized healthcare system are no longer voiced, despite the appearance that the Commonwealth seeks to expand its role. Competitive structures in healthcare have become taken-for-granted and a perception of privatized healthcare as supporting the viability of the public system has formed. The perceived unsustainability of a universal health insurance scheme suggested by a burgeoning cost picture has not suggested a revision of the model which allows privatized enterprises to draw on public funds. Instead an aging population and chronic disease have become the focus driving demand and supply side strategies.

The ubiquity of information technology and information systems has supported views of information management as necessarily efficient, progressive and the right thing to do, though it has not proven to be a sufficient argument for practice change. The information structures which support current institutional arrangements are constraining alternate explanations about the right way to practice medicine. A view of information as intrinsic to healthcare practice is supported
by standardized metrics which subject the body to a description of statistical variances against the norm, and risk parameters. The possibility to influence views on the right way to practice medicine is offered by ideas about information which inform a conception of healthcare as an information service.

6.10 Conclusion

Information and its elevated status in an information age, understandings of the market as capable of superior efficiency in relation to distribution of services, and a concept of accountability taken beyond compliance to notions of acceptable standards of performance have combined to create the climate for change in which eHealth is being proposed as a possible solution to the problems of healthcare. Within this climate of change the problem of quality healthcare is presented as a management issue of resource utilization and risk mitigation. Information ownership as vital to the effective management of healthcare is an idea which has its roots in Commonwealth involvement in setting the direction of healthcare, and was cemented during the disputes of the 1970’s. During the 1990’s this was extended to suggest information ownership as vital to the effective management of quality healthcare, an idea which has shaped the recent reform efforts. Involved in ensuring quality healthcare, information systems have a role in directing the practice decisions made in private enterprises tasked with delivering health services. Steering from a distance, the potential exists for the Commonwealth to influence practice decisions through information systems in a publicly funded fee-for-service model. The institutional structures which support the professions claim to ownership of patient information have been suggested as the existing systemized information structures and notions of privacy linked to confidentiality. Challenges to these institutional structures in the form of integrated information systems and patients changing values towards information privacy are suggesting strategies for resistance such as retention of information silos and limited information sharing. Constraining the effectiveness of resistance strategies are econometrics which exclude professional explanations of ‘care’ in shaping understandings of quality healthcare.

Since its inception the two system approach to healthcare delivery has involved the Commonwealth in offering explanations of causation of disease as preventable lifestyle choices. Cumpston’s (1919, 1928, 1942) battles to subordinate curative to preventative healthcare
highlighted the constraints placed on the mechanisms for delivering services which recognized this understanding of healthcare by the institutional structures which support professionalism. The current reforms are positioning preventative healthcare as a choice to self manage risk factors associated with preventative illness or seek interventionist approaches within competitive structures. A disease focused view of healthcare supported by care plans, broad categorizations of disease, multidisciplinary teams and a knowledge base informed by evidence, is being introduced into the privatized fee-for-service model and diffusing ideas about prevention into practice. The dual policy focus of responsibly funding a universally accessible public health service, while maintaining a policy of distancing itself from direct service provision, and simultaneously supporting competitive structures has resulted in seemingly contradictory policies aims. These policy aims tie together ideas about consumer choice in preventative health markets and ideas about quality healthcare as involving self management of preventative risk factors deliverable through the institutional structures which support curative medicine. eHealth is proposed as the tool which would subject the profession to administrative techniques influencing compliance and allowing the Commonwealth to determine the direction of practice. Rather than being driven by a technical imperative for change, the introduction of health informatics is facilitating a power transfer. As a depolitising tool for change, information systems in healthcare, from disease registers to Casemix, have had mixed results. The Commonwealth can influence but not control the outcomes of reform, application of eHealth to support the interventionist approach to prevention rather than offer patient self management of risk factors is possible. Despite attempts to tilt the balance from intervention towards a self management discourse, the power centers which uphold the status quo are well institutionalized and sanctioned. The unintended consequence of policy remains unknown but the potential for eHealth to be appropriated to support the institutional structures of professionalism exist. The consequences of this in a single system approach to healthcare delivery could be significant.

The main themes that have emerged as a result of the analysis so far in this thesis fall into three distinct groupings. Firstly, it has emerged that the explanations of administrative decisions as non political have been rejected by the profession and have altered the desired direction of policy implementation leading to renegotiated systems. Secondly, the systemization of information during periods of significant reform disrupts the discursive formations and becomes the medium
through which the legitimacy of professional and corporate control mechanisms are contested. Thirdly, renegotiated systems indicate the ideas that have been accepted and those that have been delayed or postponed to be reintroduced in future policy activity, in the current reform period ideas about health as a competitive good are proving incompatible with ideas about health as a public good. I have suggested that the struggle for a legitimate role in directing healthcare has been the drive for healthcare reform, corresponding to the broader community debate over the role of Government in society, views on health as a public good and views of health as a competitive good are constituted within these debates. A discussion about the implications of this for health policy analysis and eHealth policy in particular forms part of the discussion in the final chapter.
Chapter 7

Policy Process and the Systemization of Information in the Australian Healthcare Setting: Conclusions

7.1 Introduction

This study focused on the problem of how to conceptualize power and relate power to discourse and on how to integrate these ideas of power into a conceptual framework for policy analysis. The potential of information systems in the practical management of social and political problems in healthcare, the political context, was explored. A Foucauldian concept of power in which power was conceptualized as present, both obvious and hidden, as operating through taken-for-granted mundane routines and techniques, which positions resistance as central in exercises of power, and which provides a more direct analysis of power relations was utilized. This study has examined the discursive spaces for action, which this thesis has argued are created to support the transition of policy to practice.

This research has based its investigation of the functioning of discursive practice on the systemization of information in the Australian healthcare. The study has demonstrated the role of information systems in diffusing reform ideas into practice. The thesis began from an understanding that policy making is a political process. Rather than viewing policy as rational and comprehensive in its intention and objectives subject to the influences of politics, economics and society (Barraclough, Gardner, 2007:117), the starting point for this thesis was that policy is political and involves shaping understandings of what is rational and comprehensive to meet its objectives. This thesis contributes to the body of critical empirical research. The conceptual framework utilised, and theoretical evaluations have implications for both health policy analysis and technology adoption research. In particular, the study has implications for health policy initiatives which seek to utilise information systems to enable a political exchange.

The critical interpretativist perspective adopted for this study drew on critical theories contestation of the notion of inevitability. The study utilized a Foucauldian conceptualization of
power to illustrate the role health information systems’ play in steering acceptance of a techno-economic regime. In depicting the existence of resistance, the study indicates that alternative explanations of the problems and solutions of healthcare do exist. This thesis has questioned the dominant rationalities characteristic of the health information systems discourse – scientific, medical and managerial assumptions – to investigate the transformative potential of eHealth and demonstrate the incompatibility of ideas about health as a competitive good and health as a public good which support contradictory aims for professional practice and eHealth.

In this thesis knowledge as a social construct was recognized. The genealogical analysis undertaken in this thesis followed the construction of two core ideas which have shaped the Australian healthcare setting: 1) healthcare is manageable, and 2) quality healthcare is deliverable through the ‘right’ practice. The analysis is embedded in the ‘relation between forms of discourse, the historical struggle in which they are immersed, the institutional practices to which they are linked and the forms of authority they presuppose’ (Dean 1994:71). The creation of economics as an area of expert knowledge has supported the Governments claims to being able to manage the economy. The central struggle in the Australian healthcare setting is acceptance of a role for Government in setting the direction of healthcare. The idea that healthcare is manageable supports the Governments claim to a role in the central coordination and planning, legitimized through its claim to expert knowledge in the area of financial management. The idea that there is a ‘right’ way to deliver quality healthcare underpins the professions claim to expert knowledge and autonomous practice. These ideas have become central to the healthcare system and are considered rational and correct, thereby constraining questions about the premise upon which these core ideas have been built. Since the establishment of a Commonwealth Department of Health in 1921 in Australia, ideas about the manageability of healthcare have been supported by the systemization of information. Information systems have been seconded to support the idea of healthcare as manageable, but have been unsuccessful at resolving the incompatibility between ideas about healthcare as a public good and healthcare as a competitive good. Foucault (1991) encourages an examination of the systemizing of information as a normalizing procedure inherent in the epistemologies revolving around it. This study revealed the unexpected backlash between the systems of
knowledge – corporatism and professionalism - which played out in struggles over information systems resulting in renegotiated systems.

7.2 Re-visiting the Research Questions

Chapter One outlined the main research questions to be addressed in the thesis:

What are the impacts of corporate versus professional control mechanisms on the adoption of health informatics in Australia? This then raised the following related question, What is the impact of power and politics on the adoption of health informatics in Australia? and the following sub questions:

- How can power and politics be understood to operate through information systems?
- How can power and politics be understood to influence the translation of policies to practice?

The first question was addressed by studying the relevant literature and through interviewing a range of health practitioners who had a stake in eHealth. The findings are covered in Chapter 6 and will be discussed further in this chapter. The literature review spanned the disciplines of health policy and information systems, and informs the implications for theory discussed later in this chapter. The second question focuses on the meaning attributed to health policy, and the impact of the interpreted meaning for the adoption of health informatics. This was addressed by placing the processes of conceptualizing, conceiving and using health information systems within the health policy process. The analysis traced the ideas which inform understandings of the health system and health information systems. The impact of interpreted meanings of policy on renegotiated information systems at key points in the history of healthcare suggested the potential consequences of current reforms.

The research sub questions follow from and informed the previous question. A view of power and resistance informed by Foucault, and a concept of policy as discourse and policy as text (Ball, 1993), shaped the conceptual and analytic framework used to address the exercise of power and the influence of the political context. The first of the sub questions was addressed by assuming the transformative possibility of information systems, while recognizing that
information system development is neither predefined nor determined, providing scope for negotiation. Analysis of the systemization of information as a history of the present focused on the implications of power and politics in utilizing information systems to diffuse reform ideas. The second of the sub questions was addressed by assuming the political nature of policy, and the possibility for resistance during discursive transformation. The findings relating to these sub questions and the main research questions are discussed in the remainder of this chapter.

7.3 Implications for Theory

The theoretical contributions of this study reside in its contribution to: 1) the application of critical concepts such as the history of the present to empirical research and validating such an approach: 2) presenting and critically discussing health policy and health information systems in light of the changing role sought by government: 3) a conceptual framework for critical health policy analysis which responds to what is at stake: and 4) bridging the academic fields of IS and social policy analysis, viewing IS adoption issues as resistance to ideas. This section will expand on these contributions.

Application of critical concepts to empirical research in IS is not a new approach, as discussed in Chapter 2. The contribution of this thesis lies in bringing together critical concepts drawn from the discursive and disciplinary work of Foucault and the sociology of the professions and suggesting they are compatible and applicable to a study of health IS acceptance. IS as a multidisciplinary area has a history of borrowing from other disciplines (Dabrowska-Klecun (2002:258), and has encouraged such an approach (Doolin 1998:1). This thesis continues this tradition but also encourages the ‘lending’ of IS theoretical developments in approaches such as critical interpretivism to other disciplines. This thesis has demonstrated the feasibility and validity of critical research combined with empirical study and theoretical analysis, providing new insights into the diffusion of reform ideas and eHealth adoption. Doolin (2009:211) suggests ‘the visibility that IS provide to particular aspects of organizational activity means they become objects around which interests are negotiated and political processes enacted’. This study has demonstrated that a focus on renegotiated information systems illuminates the reform ideas being resisted, and those accepted into practice, suggesting the utility of focusing on the
practice of systemizing information for policy studies. This thesis is limited by its concentration on Government rather than a broader global view of capitalism, favoring critical concepts of local sources of knowledge and power (Foucault, 1980), and so can make no contribution to perspectives on the relationship between society, policy and technology. Local applications of health policy and practices of information systemization were considered important to this study, where the preservation of a universal health insurance scheme was advocated.

The central concern of this study has been to understand the positioning of eHealth within the health policy process. The critical interpretivist research approach, utilizing the concept of the history of the present, steered the investigation towards the origin of self-evident understandings of concepts such as health is manageable and concepts relating to the ‘right’ way to practice healthcare, showing how at certain moments they became a principle component in our understanding of how to frame problems and offer solutions. The contradictory aims of current health policy initiatives which seek to diffuse ideas about health as a competitive good and ideas of health as a public good through eHealth were illuminated utilizing the conceptual framework described in this thesis.

7.3.1 Methodological Contributions

The analyses presented in this thesis focus on the neglected resistances in the history of healthcare policy. This focus provided insight into the unresolved disputes that this thesis argues are impacting on current adoption behavior. The concept of power relations proposed by Foucault (1976, 1977, 1979, 1980, 1982), as social relations which can be challenged and/or modified, was utilized to highlight the nature of power and politics in the positioning of information systems in the policy process. The focus on the forgotten resistances during critical events in the health policy history, periods which represent the usurpation of power, drew into focus the contestation between professionalism and corporatism and strategies deployed to resist and maintain the status quo. Discourse was understood to represent the medium through which power relations create speaking subjects, represented by practices of talk, text and argument. Discourse determines who has authority to speak and that which can be spoken. Evidence was presented of the ‘complex and unstable’ nature of discourse through the presentation of the
unintended consequences of the policy process demonstrating the double edge of discourse as ‘an instrument and the effect of power, but also a hindrance, a stumbling block, a point of resistance, and a starting point for an opposing strategy’ (Foucault 1979:101). Conceptualizing policy implementation as the point of discursive transition, the policy analysis was able to utilize data from three layers – macro, mezzo and micro - to identify subtle disciplinary practices capable of producing knowledge that is inseparable from power. Analysis of the discursive rules which came into effect following resistance represented the modified power relations, the renegotiation of meaning and the delayed diffusions.

Discussed in Chapter Two is the challenge set to critical researchers to define a methodological and analytical approach for empirical research. An important contribution of this research is the inclusion of layers of data related to critical events and incorporating practitioner perspectives in a critical policy analysis. The layers of data illustrated the interplay of political practices, local interpretations, and strategies employed at the point of discursive formation.

7.3.2 Contribution to a Conceptual and Analytical Framework for Policy Analysis

The genealogical analysis undertaken revealed the policy tools which make up the policy technology deployed to create the climate for change necessary for translating policy into practice (Ball 1995). The analysis revealed discursive practices giving rise to knowledge, the pervasiveness of administrative disciplinary tactics of evidence, accountability and metrics. This thesis suggested that influencing the formation of discursive spaces for action is of primary concern in the translation of policy to practice, offering both sites of resistance and sites for altering power relationships. This study argues that policies which propose information systems as the solution to policy problematisations open up new discursive spaces, utilizing knowledge structures and other institutional arrangements. This study suggests that information systems are positioned within the discursive spaces as either strategies of resistance (in this study information ownership and information silos were described) or as policy tools. The deconstructionist approach taken in this thesis suggests that focusing on the disruption to discursive formation illuminates resistance strategies. Resistances can impact the discursive rules which come into
affect, limiting or expanding opportunities for power redistribution. The study argues that points of discursive ruptures have their genesis in the ideas and not the practices being diffused.

The policies, interpretations and strategies studied here suggest that eHealth is being employed to support a role for the Government in: 1) directing self management of health; 2) promoting public health principles: and 3) supporting a concept of health as a competitive good. Doolin (1998, 1999, 2004, 2009) and Klecun (2005) suggest information systems acquire meaning within a managerialist discourse, and in turn reinforce managerialism by enforcing control and monitoring. The use of information systems to introduce practice change is emphasized. This thesis has supported this view of information systems but has argued that the meaning acquired by health information systems employed in the political context is rooted in the history of ideas about health and information which inform the present. Some of the broader ideological influences impacting the meaning ascribed to policy and interpretations made of information systems were highlighted by utilizing the concept of the history of the present and by focusing on the systematization of information as the discursive practice.

Relating information system deployment to tactics of governmentality provided the means for making sense of the possibilities, and responses to, the role of information systems within policy initiatives. The study demonstrates the utility of understanding the practice of systematization of information in healthcare, the tactics which underpin the taken-for-granted ‘manageability’ of information in healthcare and its relationship to the history of the present, in providing an interpretative framework in which the motivations and responses to information system can be examined.

**7.3.2.1 The concepts of professionalism and corporatism**

In this thesis corporatism and professionalism have been conceptualized interchangeably as control mechanisms and governance modes or power/knowledge systems. A view of professionalism as a form of occupational control in the management of professional groups through promulgation of a professional ideology which had the effect of regulating behaviour in particular ways and bringing with it associated structures: relatively undifferentiated levels of reward, flat hierarchies and equality of status, supported an understanding of professionalism as
a governance mode (Ozga 1995:29, Fournier 1999, Freidson 1994). Institutional arrangements which include professional bodies, endorsed research methodologies and funding mechanism support notions of the efficacy of expert knowledge and notions of an ethical professional allowing the medical profession to exercise authority. This thesis has explored the elevation of administration and economics within healthcare as it sought to bring about structural change through establishment of expanded national statistics, research programs, and provision of data, in support of: 1) notions of efficacy in financial management expert knowledge: and 2) notions of objectivity and rationality in administrative authoritarian techniques.

This thesis has accepted a role for Government as involved in the calculated administration of diverse aspects of conduct through tactics of persuasion, inducement, management, incitement, motivation, and encouragement (Cohen, 1985, Rose and Miller, 1992:175). As a domain of cognition, calculation, experimentation and evaluation it is intrinsically linked to the activities of expertise (Rose and Miller, 1992), and is interlinked with corporatism. In this thesis professionalism and corporatism were considered as power/knowledge systems from a Foucauldian perspective. Professionalism and corporatism bring ‘life and its mechanisms into the realm of explicit calculation’ (Foucault 1976:143) through the application of the mediations of governmentality in practices and procedures such as maintaining confidentiality of information, which this thesis has proposed operates to impose authoritarian techniques in support of agreeable institutional arrangements. This conceptualization provides an alternative to the categorizations of dominant structures suggested by Alford (1975).

7.3.2.2 The history of problemization

‘It is the history of problematizations that is the history of the way in which things become a problem’ that is the focus of genealogical analyses (Foucault, 1997:414). The localized struggle investigated in this thesis was the relationship between the systemization of information and exercises of power in the Australian healthcare setting. Policy discussions are held and policy texts are written in response to particular problematizations of health, suggesting the potential of certain solutions and causing others to be ignored. The localized struggle in the Australian healthcare setting was viewed from the micro level of operationalising information systems in support of policy. Engaging with interpretations of policy, this study suggests that the choice of
measures of socio economic and risk factors in explanations of the problem of healthcare are influenced by Government concerns for legitimacy under changing dominant economic orders. Further, the thesis suggested information systems are engaged to provide a neutral rational grounding to these choices of measures in an attempt to depoliticize debate. The evidence presented in this thesis is that as a depoliticizing tool, information system provides mixed results.

7.3.2.3 What is at stake

This thesis has described what was to be gained by achieving health policy objectives, utilizing concepts of legitimacy and jurisdiction to understand what is at stake. The connection between expert knowledge and reward was understood from the perspective suggested by Bourdieu (1984:93) as the impenetrability of expert knowledge which authorizes the qualified to speak with authority about what constitutes the field, providing cultural authority. This authority allows for framing of problems and proposal of potential solutions. Abbott (1988:59) describes professions as bound to a set of tasks by ties of jurisdiction, and the strengths and weaknesses of these ties being established in the processes of actual professional work. Legitimation justifies both what health professions and Governments do and how they do it, allowing for a claim over jurisdiction (Abbott 1988:185). Legitimation of means – management, diagnosis, treatment - begins with the legitimation of professional activity (Abbott 1988:189). The grounds for the legitimacy of health professional techniques are based on understandings of what is rational technique and notions of ethics in professional work. Claims for jurisdiction bring more than a division of labour and rights such as absolute monopoly of practice and of public payments, rights of self-discipline, training licensing and so forth, they also bring cultural authority (Abbott 1988:59). Professionals in societies which value specialized expert knowledge (cultural capital) and which are structurally unequal, can expect to benefit in the form of market opportunities (economic capital) and status (authority to speak or symbolic capital) and work privileges (social capital) (Bourdieu 1984:96). In this thesis jurisdiction has been conceived as denoting the discursive boundary, delimiting the groups who have authority to speak on the actual professional work performed. Legitimating the right to speak is expert knowledge, which has been conceived in this thesis as an institutional arrangement supported by institutional structures such as the NHMRC, and government commissioned studies (e.g. Quality in Australian Health Care Study), allowing for a claim over jurisdiction. This thesis has noted the shift in legitimating
the expert knowledge of the health professions as reliance on scientification, transparency through administrative performance reporting, and evidence on the efficiency of practice. While Abbott (1988) would see these changes as reflective of value shifts in the larger culture, applying pressure to professions to move towards these legitimacy bases or face erosion of jurisdiction, it has been the posited in this thesis that the value shifts in the larger culture have been steered by policy to create the opportunity for the erosion of health practitioners claims over jurisdiction. Investment in research to create and expand areas of knowledge – knowledge which can support a new economic order or areas of medical enterprise – pose a challenge to the expert knowledge upon which existing jurisdictional claims are made. The construction of a concept of the manageability of quality and safety in healthcare through policy as discourse was explored in this thesis, suggesting a change in the jurisdictional boundaries of ‘care’. In this thesis it is suggested that such a change is enabling the health professions claim for jurisdiction to be questioned. Other groups more amenable to competitive structures, including health informaticians, are being positioned to claim recognition of expertise.

7.3.2.4 Information systems as Discourse

A Foucauldian concept of discourse was employed in this thesis. Discourse is understood as the medium through which power relations create speaking subjects, as not just setting the tone of the dialogue but determining how subjects should be perceived and spoken about, and who can speak. The dominant discourses in health care create the understanding of health as manageable and quality healthcare as deliverable through the ‘right’ practice. In this thesis it has been argued that in order to shape this understanding of healthcare a number of discourses are employed.

This thesis describes the contribution of systemized information to the larger health policy objective. Information systems have been conceptualized as health policy tools within a larger policy technology (Ball 1995), and as a discourse within an amalgam of discourses (Bartlett, Knight, Lingard 1991) which combine to make up the discourses of corporatism and professionalism in healthcare. In this context, technology refers to any assembly structured by a practical rationality governed by a more or less conscious goal: Human technologies are hybrid assemblages of knowledges, instruments, persons, systems of judgment, buildings and spaces (Rose, 1999:26). Ball (1995) refers to technology as 'coherent or contradictory forms of
managing and activating a population' which lends itself to tactical applications (Ball (1995:260)). In both instances the questioning of the more or less conscious goal of technology became the concern. This thesis argues that since the 1970’s economics and statistics have been applied to provide the epistemological demonstrations which are valued to influence the direction of healthcare. It has been further argued that this laid the groundwork for the reconceptualisation of healthcare within a financial management discourse providing a technology of measurement (metrics) and surveillance (accountability). The evidence suggests that efficiency and performance metrics re-centered the profession and hospital administrators as the focus of causation in explanations of inequitable access: displacing or quieting other explanations related to the wider consensus that the central problem of health policy was the subsidization of acute services increasingly under the direction of privatized enterprises.

The focus on measurable outcomes also articulated directly with the political process of introducing competitive structures into healthcare, supporting a concept of the manageability of normative health outcomes as achievable through the actions of individuals. This study has suggested metrics, evidence and accountability developed a technology of control which enables the monitoring and 'steering' of health professional responsibility for translating health policy into practice and individual responsibility for behavioral change. The application of 'progressive' and efficient technical solutions to designated problems (Ball 1995:262-3) forms part of the ensemble of Governmentality (Foucault 1979:20). The discourse of health information systems as transformative, as neutral, as progressive and essentially rational, and as necessary provides it a place in the ensemble of Governmentality. As the means through which speaking subjects are created, ideas about health performance metrics, evidence based practice and a broad concept of accountability as objective, rational and necessary in healthcare are diffused through health information systems. The process of systemizing information involves a painstaking review of all points at which information is created, exchanged, withheld, interpreted, the communication process as it unfolds between patient and doctor, doctor and colleague, doctor and other providers. Through the examination of process and flow, advice and improvements can be offered at all stages to all players, scrutiny, judgment and norms can be applied. A new rationality of cost consciousness and resource utilization can be introduced, diffusing these reform ideas by engaging information systems. The significant discursive and disciplinary work
of a health financial management framework, demonstrates ‘the play and effects of power’ (Ball, 1995:261) 'the panopticisms of every day' which are constructed and enacted 'below the level of emergence of the great apparatuses and the great political struggles' (Foucault 1977:223). While the evidence presented in this study highlights the taken-for-grantedness of the financial management framework in healthcare, and the constraints this places on understandings of healthcare, the focus on renegotiated systems has suggested the possibilities for resistance.

Viewing information systems as the medium through which power relations could create the speaking subjects in healthcare, that 1) health as manageable supported economists claim to a role in steering the direction of healthcare and 2) quality healthcare as deliverable through the right practice supported administrative practices claim to a central role in healthcare delivery, provided practices as the site for exposing the effects of power while focussing the analysis on the machinations of power. The Foucaudian concept of discourse which signifies the point of departure for this thesis provided the framework for analysis. Yet, it was considered necessary to structure the analysis to allow for the genealogical analysis to be performed across various critical events in a consistent manner. The act of structuring and framing the analysis allows the researcher to determine what is of significance and what ideas should be drawn on – the research then becomes the medium through which the researcher determines the right way to problematise, exposing the researcher to the play and effects of power. The Foucaudian discursive analysis does not provide an easy solution to this dilemma. The researcher cannot lay claim to significant findings or make undisputable claims but must be content with having opened up other possible explanations of phenomenon.

7.3.2.5 Operationalising Policy

The transition from health policy to practice has provided the focus for this thesis. The event being explored was the systemization of information within the larger event of operationalising policy. The nature of policy described in this thesis inhabits two different conceptualizations – policy as discourse and policy as text. Ball (1993) refers to policy as discourse, taking its meaning from the Foucauldian sense. Policy as the medium through which social relationships are defined relates to agency and is conceptualized by Ball (1993) as policy as text. Policy discourses produce the ‘framework of sense and obviousness’ (Ball, 1993:11). Viewing policy
through this lens, this study recognizes policy making as involved in shaping (policy as discourse) and interpreting (policy as text) economic, ideological, political and social considerations. This thesis has examined the mundane programmes, calculations, apparatuses, or ‘governmental technologies’ within the Australian healthcare setting which were significant for their enactment of government ambition (Rose and Miller, 1992), focussing on the historical shifts and changes in the form of the exercise of power (Foucault 1979). The diffusion of more subtle and economic forms of power over individuals working in healthcare has been explored through examination of the diffusion of a health financial management framework. This thesis has suggested that in the case of governmental technique executed in healthcare, the exercise of power has continued to involve the more formal processes of legitimacy of funding and regulation.

A Foucauldian analytical framework was utilized in this thesis to show that: 1) there is no necessity in the history of healthcare in Australia determining that health is manageable or quality healthcare is deliverable through the ‘right’ practice, other than to serve a political function, and 2) to discover the complex of ‘factors, connections, strategies and forces’ which precipitated the taken-for-granted position of eHealth as self-evident and necessary (Smart 2002:58). The analysis was executed along two dimensions: 1) the set of conditions which were present at a moment in time making it possible for transformation of discourse to occur, relating discourse to the practical field in which it is deployed to become ‘self evident’: and 2) the rules which came into affect so that all of the concepts, operations and theoretical options of health discourse are influenced, creating the taken-for-grantedness (Foucault 1979:58-60). This analysis of the influence of health policy as discourse on ideology, politics, economics and social plays suggests that the transition of health policy into practice involves negotiation and renegotiation and the unintended consequences of the compromises of contestations add to the complexity of attaining future health policy outcomes. The focus on renegotiated health systems in this analysis highlighted the affect of haphazard conflicts, chance and error of relations of power – the local criticisms of the discourses, practices and institutions (Smart 2002:59). In this thesis it has been argued that the health policy tools and policy technologies which are deployed to overcome the complexities of meeting health policy objectives seeking institutional structural change are themselves the subject to negotiation and renegotiation.
It has been contended in this thesis that renegotiated health information systems are the outcome of policy negotiation and highlight the ideas contained in health policy objectives which are accepted into practice and those postponed. The evidence presented demonstrates the implied understanding by social actors in healthcare that information systems power to document provides it the ability to serve simultaneously as: 1) a type of technical control of healthcare costs; 2) a political exchange allowing the Government to redistribute power under broadening definitions of efficiency, quality and equity; and 3) as a discourse legitimizing the need for continued Government intervention in the determining the direction of healthcare – healthcare as manageable through the application of management techniques. It has been argued in this thesis that information systems become a site of contestation when the potential of information systems for health as a discourse is recognized.

This thesis has suggested that health policy contexts create new discursive spaces for action, spaces which provide opportunities to maneuver allowing for framing of issues or resisting practice change. It is within these spaces that the political landscape of action is made apparent. This thesis suggests that within this landscape information systems become the medium through which the legitimacy of professional and corporate control mechanisms are contested. It has been further argued that an interpretive system which motivates ideas about information systems, or eHealth, operates within this space.

The analyses conducted in Chapters 4, 5 and 6 supports an argument that health information systems deployment is essentially political and influenced by power associated with claims for legitimacy and jurisdictional boundaries.

### 7.4 Aim of this thesis

The aim of this thesis was to write a health policy analysis, not of the implementation of information systems, but of the practice of systemizing information. The intention was to illuminate the motivations of policies, clarifying the role of information systems in policy and practice, and allowing for an explanation of resistance to adoption. An explanation other than
the stark opposition of ‘intervention’ and ‘autonomy’ was recognized as necessary to provide an account of the complex relationship of the Government to the provision of healthcare (Gillespie 1991:xi). The study examined the role of information systems as a political tool in effecting reform. Further evidence is provided here of the difficulty in bringing about changes to the institutional structures which support the established providers of health services.

This study set out the context for analysis by describing the political context and the positions of influence that have their history in the establishment of a Commonwealth Department of Health in Chapter 4. The move towards competitive structures in healthcare and the role for information systems in steering the direction of healthcare from a distance were studied through the deployment of Casemix in Chapter 5. The further migration towards a market society and the role of Government in nudging consumers’ choices with respect to preventative self management of healthcare supported through access to information was explored in Chapter 6. The understanding gained from studying critical events in health history can contribute to an understanding of the present and is discussed in 7.5. The implications for operationalising policy are discussed in 7.6. The discursive spaces for action which provide the opportunity to maneuver suggesting professional strategies for maintaining the status quo are synthesized in 7.7. Finally, the implications of the analyses for eHealth policy initiatives are presented in section 7.8.

7.5 What History tells us about eHealth Policy

The focus has been on the role of the Australian Commonwealth Government in controlling the direction of healthcare. The early periods of significant reform aligned themselves with the aims of Labour governments, which sought to increase the role of the Commonwealth in the delivery of health services. The medical profession were present in influential public administration positions during the establishment of a Commonwealth Department of Health in 1921. The experience of war and centralised coordination of healthcare services combined with preventative approaches to disease management and a view of illness as avoidable suggested a role for Government in public health beyond quarantine. Debates surrounding such changes were, for the most part, carried out in the public domain, with the newly federated Government responsible for convincing the electorate of the merits of change. Debate centered on
preventative as the right way to practice healthcare and as an issue important to maintaining a healthy productive white workforce linked to the national building and economic welfare. The Governments authority to speak on preventative care was legitimised by expertise in epidemiology and statistics. The negotiation which followed saw a two systems approach to the delivery of healthcare in which the Government assumed responsibility for public health and the profession retained control of individualised curative healthcare. The dual approach has dominated the health setting ever since, providing the key stakeholders authority to speak on practice issues. A critical role for the medical profession was recognised in the dissemination and collection of patient information, shaping the Government and the professions mutually interdependent relationship.

Further attempts to extend Government influence in the practice of healthcare during the 1940’s and the 1970’s utilised areas of new knowledge in pharmacology and computerised administrative techniques respectively to extend jurisdictional boundaries. During the 1940’s institutionalised structures supported existing arrangements to limit Government to influencing rather than controlling the impact of reform. However, ideas about over servicing and the need for oversight into professional practice were diffused. The idea that a national health system was necessary to ensure equitable access to quality healthcare, ideas formulated in the 1920’s and 1940’s were accepted in the 1970’s. During the 1970’s the scope for an expanded role for the Government in determining practice was supported by the introduction of a popularly supported publicly funded health insurance scheme, and the ideas about over servicing diffused in the 1940’s. Evidence presented in this study indicates that ideas about healthcare as manageable through tighter administrative oversight and manageability as contingent on health information were formed during this period. The renegotiated Medibank computer system was given a reduced role from monitoring practice behaviour to providing billing information. The reduced role failed to constitute medical practice as manageable, reflecting the accord reached by the profession and the Government. The evidence suggests that as a technically manageable problem, healthcare became an area of government responsibility, however without a legitimate role for corporate control mechanisms in the management of healthcare.
Later reform periods supported efforts to introduce competitive structures into healthcare, distancing Government from direct service provision while retaining responsibility to fund the popularly supported universal health insurance scheme. Health economics was the area of expert knowledge assumed by the Government legitimising a view of healthcare as a technical issue of applying competitive structures to manage cost and quality. Casemix activity based funding was introduced in Victoria in the 1990’s. Underpinning Casemix was the idea that healthcare outcomes were manageable through the application of administrative techniques of categorisation and performance metrics. Metrics allowed for scrutiny of professional practice from outside the professional boundary, providing hospital administrators with a voice in describing the best way to practice. The scope of quality healthcare was broadened to encompass cost effective resource utilisation. I have suggested that an amalgam of policy tools including market, accountability and evidence were deployed through Casemix constituting a policy technology which brought about a changed understanding of healthcare. I have argued that an understanding of information as tied to quality through efficiency and resource allocation supported a view of the problem of healthcare as a technical issue of applying competitive structures to manage cost and quality and a concept of equity as equitable access to funds. A narrow understanding of efficiency was accepted representing the renegotiated system.

Recent steering of the market society has involved Government in nudging consumers to make the ‘right’ choices. Recognising, as Cumpston (1919) did, the ‘strategically almost perfect’ position of the profession for dissemination of information, public health principles are being deployed through private practices providing a choice between preventative self management approaches and interventions. Cumpston (1919) envisaged a preventative agenda which would nationalise part of the knowledge and time of every practicing doctor. Today the knowledge and time of practicing doctors is being procured to provide team based disease focused approaches to healthcare. Cumpston sought to use disease registers to change the way healthcare was understood. Today, conceptualizations of the problem of quality healthcare as a technical issue of managing preventable risk factors are being underpinned by health informatics. Ideas about information shaped during earlier reforms, suggest medical information as positive fact and as vital in the management of healthcare. I have argued that the role of informatics is being extended to conceive of information as vital to quality outcomes in healthcare. This role for
informatics supports a new role for Government in healthcare, from ensuring equitable access to managing and supporting productivity.

The series of contests and renegotiations surrounding the role of information systems in healthcare during the periods of reform studied reveal that the political context is a factor in the systemization of information and adoption decisions. When recognized as a political tool, integrated information systems become contested sites, leading to a renegotiated role. I have argued that the role that information systems secure in the governance of healthcare reflects the ideas diffused into practice, demonstrating the accord reached between the major stakeholders. I have also argued that promotion of new areas of knowledge such as epidemiology, pharmacology, social science and health economics have provided the Government the epistemological demonstrations valued by the profession affording legitimacy to claims of expert knowledge in population health, preventative and administration of healthcare. Authority to speak on what constitutes quality healthcare remains an area of contestation between the Government and the profession. Recently Government has claimed expert knowledge with respect to information standards and security protocols in support of control over the jurisdiction of health informatics. Unable to convince the profession of its ability to deliver ‘quality systems’ is delaying legitimacy processes. Legitimacy is required to support ‘consumers’ assuming greater responsibility for health outcomes and their own health resource utilization, aided by eHealth solutions.

Without the epistemological demonstrations of efficacy the benefits of eHealth are being disputed. The uncertainty and vagueness of the policies, and the perceived lack of political will, have exposed the electronic health record to derision in some quarters as either a nebulous term or the ‘Holy Grail’.

7.6 Implications for Operationalising Policy

It has been argued in this thesis that policies reflect how government sees its role, moving from governing a society in a welfare state to governing an economy in a capitalist state. Health policies have reflected a move from state responsibility to individual responsibility, with a continuing state responsibility for controlling the direction of healthcare. The concept of history
of the present which guided the examination of information system implementations in healthcare drew the focus back to the overarching debate which has shaped, and continues to shape, the healthcare policy landscape, the role of the Commonwealth in determining the direction of healthcare. Substantial evidence has been provided of the conflict generated over Commonwealth involvement in healthcare. Institutional structures support a limited role for the Commonwealth, while popular support exists for a universal health insurance scheme. The analysis of ‘successful’ policy implementations in previous chapters’ which including Medibank and the Victorian Casemix reforms, highlighted that when perceived as an attempt to increase the role of government in steering the direction of healthcare, political will and a perceived need for change was required. The analysis of documents, and first hand accounts, suggests that implementation of national shared information systems in healthcare, where successful, have involved renegotiation and compromise providing further evidence of the difficulty of bringing about change to the institutional structures which support the existing service providers. The analysis further shows that conflicts were rarely resolved, the negotiations were ‘stop gap’ with the broader aims of reform considered to be delayed rather than achieved.

Equity and access still feature in policy documents borne of the ideology of social justice, granting legitimacy to government involvement in provision of social services, but which was abandoned in the 1980’s in Australia. Evidence has been presented that understandings of equity in healthcare have changed from equitable access to services, to equitable access to funds and finally to equitable access to information. Governments’ responsibility for equitable access has been responded to by initiating policy text responses to the changed understandings of equity. Ensuring freedom of choice between public and private providers, and more recently between preventative and curative approaches, and affordability, is increasingly the justification given for government involvement in health services. eHealth policy initiatives while still using social justice rhetoric ‘quality healthcare for all’, are couched in terms of ‘empowerment’ of ‘consumers’ encouraging individual responsibility, while pursuing centrally controlled datasets and repositories. Analysis of policy documents suggests the thrust of these contradictory aims is driven by a continuing requirement to responsibly fund a universally accessible public health service, while maintaining a policy of distancing itself from direct service provision. The benefits of eHealth are often vague, contradictory - seemingly delegating to community and
industry the responsibility to exploit the full potential while concretely focused on administrative oversight - reducing the influence of the government to achieve desired outcomes throughout implementation.

Policy implementation in a market based economy for a government funded service is complicated by the partnerships the governments must enter into with independent legal entities such as the Medicare Locals, requiring the government to pay for, rather than prescribe policy outcomes. Evidence from key decision makers indicate that financial incentives offered in exchange for policy outcomes, such as the practice incentive program, do not ensure continued involvement if the benefits of reform do not outweigh costs to the provider. Evidence was presented of incentives to adopt eHealth initiatives which did not lead to long term structural change, suggesting the work of prosecuting a case for reform was not satisfactory performed.

Analysis of the reform context has highlighted the means by which a climate for change is created in order to influence outcomes. Information systems and accountability metrics which seek to mute the impact of context and history allow for the problem of healthcare to be presented as a manageable problem. This view of healthcare exists uncomfortably alongside the criticisms of the public health system from the profession, private health insurers and patients who have experienced poor service. Evidence has been provided that awareness exists amongst stakeholders that statistics and facts can be used to change understanding of organizational realities. The possibility of information systems to facilitate a political exchange has been recognized by stakeholders since the Commonwealth involvement in healthcare. In recent disputes one clear sticking point is authority to speak on what constitutes work performance and efficiency. This thesis has shown, the accuracy of the information supplied and the validity of the procedures used to construct it are called into question during disputes between key stakeholders concerning the role of government in setting the direction of healthcare. Context and history matter in adoption making decisions suggesting information systems are ineffective as depoliticizing tools. Entangled with attempts to redistribute power by legitimizing one groups view about the ‘right’ way to practice will impact on the adoption of eHealth initiatives.
The analysis of the implementation of eHealth has highlighted reasons why the implementation has not been successful. Reviewing the Commonwealth’s involvement in the deployment of information systems has identified that strong political will and a recognized need for change are necessary prerequisites to ensure success. Intricate new arrangements in healthcare are adding to the complexity of bringing about structural change. However, it has been argued that the lack of success rests more clearly on the contradictory aims of appearing to provide for a universal health insurance scheme while acting as an enabler for society as a market. The ideological battle which exists has led to criticisms of vague and contradictory policies, allowing for skepticism about the benefits of eHealth to take hold. Addressing these concerns, analysis of current reforms suggests agency is to be extended to patients, with a view to empowering consumer driven structural changes that government policy itself cannot achieve. This appears to be predicated on the belief that when given access to information, the public consumers will demand change from the providers, while simultaneously emphasizing ‘knowledgeable’ patients engaged with the preventative agenda - making patients responsible, and accountable, for managing their own health. The evidence does not explain if the intention is to exploit the duality of technology, to make people more demanding and more self-reliant, or whether this is another example of contradictory eHealth policy.

7.7 Implications for the Professions’ Strategies

The extent and legitimacy of state intervention in the provision and subsidization of medical and other health services has been the cause of conflict between the profession and the Commonwealth, and between the various levels of government, as each have vied for control of the direction of the system. Engineering a lasting settlement has been difficult to achieve. Medical resistance to state intervention, and government intervention to affect the pattern of services and access to medical care and its cost, is not a new conflict. However, this does not mean that it is no longer relevant. This thesis has provided evidence from archival documents of the strategies the profession has deployed to resist Commonwealth intervention. Viewing the past and present as correlative notions, the impact of this old but current conflict on information sharing behaviour in healthcare, and the associated impact on reform efforts has been explored in this thesis.
The thesis provided evidence that the unique feature of the Australian health system, the central influence of the relationship between the federal and state governments in shaping the system, was used by the profession to improve its own position. Exploiting tensions between the Commonwealth governments desire to expand control over healthcare and the State government’s protectionist stance, the profession successfully encouraged state government resistance in the 1920’s, the 1940’s and the 1970’s. The case of the casemix IS deployment in Victoria highlighted the professions acceptance of state initiated information systems, while resisting a similar Commonwealth Government initiative.

From the beginnings of Commonwealth involvement in controlling the direction of health, disputes over claims to expert knowledge on medical practice surfaced. Analysis of archival documents highlighted that the personalized private enterprise model of curative medicine has consistently resisted a preventative model of healthcare. Throughout this thesis, examples of information systems which became the focal point for disputes between the government and the profession were drawn on. One such exemplar was the request for prescribing information in the 1940’s which were required to gain oversight and shape practice behavior to ensure universal access to the newly discovered penicillin. This initiative was vigorously fought eventually leading to a change in the constitution (section 51, xxiiiA) of the constitution (Parliamentary library, Phillips, 1964). The core of the dispute with respect to the information system centered on the suggestion that clinical treatment is a standardized set of procedures, undermining the view of curative medicine as a professional personalized service which involves expert knowledge and confidential interactions. Characterizing the disputes as deficiencies in doctors record keeping of disease information, and resistance to any oversight of prescribing habits, and further suggesting that this helped the construction of demand for services by ignoring prevention, has framed the debate between a professional mode of medical service provisioning and a corporatist mode ever since. I have argued that the professions custodianship of expert knowledge is coveted because it ascribes authority to speak on what constitutes quality in healthcare, and consequently the direction of healthcare. I have described the use of research funding to influence the creation of knowledge shaping understandings of the cause and treatment of illness.
Evidence has been presented that the validity and accuracy of data used in performance metrics is being questioned. It has been suggested elsewhere that if the information produced by an information system is deemed inaccurate or inconsistent then this betrayal by one of the elements in the network may cause a breach ... by undermining the credibility of the whole system (Bloomfield, McLean, 1996:372). In this thesis it has been argued that questioning the validity of performance metrics and exploiting the political nature of the information used in the generation of performance measures can undermine information systems as candidates for diffusion. Casting doubt on the legitimacy granted to government generated reports on performance undermines government claims to being an efficient manager of healthcare costs, and resists portrayals of the profession as over servicing. Authority to speak on what constitutes work performance and efficiency has become contested and a new discursive space is made possible. The evidence presented demonstrates that information systems have become the medium through which claims to legitimacy and control over resource allocation are contested. The evidence from medical professionals presented here suggests this understanding of the political context of information systems is impacting on adoption behaviour.

Internationally, and locally, the medical profession underwent a crisis of confidence in the 1970s, as questions were raised over large expenditures on sophisticated medical techniques that seemed to produce diminishing returns in quality of life. While the limits of modern medicine were being recognized, it was still the case that medicine remained a significant factor shaping levels of inequalities in population health. Without a legitimate claim to efficacy, the need to justify expenditure in curative medicine and respond to claims of diminishing returns became more urgent. Without authority to speak on what constituted a quality equitable healthcare system, the political will of the Whitlam government was able to galvanize a desire for change. This thesis has drawn on archival documentation and participant interviews to understand the strategies during this transition. The data support a view of the profession as weakened but not powerless, describing the professions successful renegotiation of the role of the Medibank information system which had been initially conceived of to detect abuses of the universal health insurance system in terms of over servicing, but which was eventually implemented as a billing system following a compromise deal which transferred to the medical profession responsibility for
disciplinary powers over false or excessive Medibank claims. Drawing on the ethical professional who has a duty towards confidentiality, the profession presented the Commonwealth as invaders of privacy and information systems as portals into personal private matters. Privacy as a tool for resistance was heavily utilized during the 1970 reforms, and has become a feature of discussions surrounding the deployment of an electronic health record.

Evidence has been presented that the current reforms which include the deployment of an electronic health record are subject to resistance strategies which seek to maintain the status quo. This thesis has placed the issues of quality and privacy, issues which dominate the eHealth discourse, in the context of the historical disputes. The evidence presented supports a view of the concept of privacy and quality as political tools deployed to resist a political exchange.

### 7.8 Implications for eHealth Policy Initiatives

This study has shown that health policy that seeks change that endures needs to prosecute a case for reform which engages the public and the profession. This study has shown that quieting of alternate perspectives in the debate over the direction of healthcare through the engagement of eHealth and performance metrics will undermine the longevity of reform. The subjective nature of information systems and performance metrics will continue to be highlighted as a strategy to reject Commonwealth involvement in healthcare. Where a mandate for reform is assumed rather than granted, the benefits of eHealth will be in facilitating existing institutional arrangements rather than influencing transformational change. In the current discourse, the role of information systems in healthcare is ambiguous: they have the potential to be something fearful or something valuable.

Positioning eHealth as an empowering tool in preventative medicine allowing for self management of health is a message being promoted by the National eHealth transition authority. The benefits of eHealth stated in the National Health and Hospital Reform Commission report encourage patients to evaluate practitioners and hospitals, and support the creation of league tables, oversight information which this study demonstrates will be rejected by the profession. Misinformation is possible because the conflict between the government and the profession stemming from the Commonwealths role in directing self management of health has not been
resolved. Delegating responsibility to patients to tackle inefficiencies in medical practice, and manage their own health, by providing them with information assumes a healthy empowered population. Illness and aging disempowers, and the sick and elderly need representation, particularly in the curative medicine arena where they must inevitable turn because aging and many complications of chronic disease are not preventable. A clear, unambiguous role for eHealth, which offer real benefits to patients needs to be identified, releasing eHealth from its entanglement in political exchanges if it is to encourage adoption. This study has demonstrated wide support for improved data flows. Real benefits to patients include practice changes and financial management, and eHealth can and should play a role in rationally allocating resources. As this study has indicated an accord between the key stakeholders is needed, and influencing the profession to reform will require more than financial incentives. The argument that consumer demand will influence the profession towards beneficial reform for all has no precedent. As I have argued in this thesis it remains the responsibility of the Commonwealth to prosecute the case for reform.

eHealth can only be considered ‘transformational’ if it encourages patients to take responsibility for the management of their health, and allows for oversight of service provisioning. Framing the debate are policy initiatives which allow for a redefinition of healthcare as a manageable information service. This thesis has demonstrated that this proposed new view of healthcare exists uncomfortably alongside the existing view of healthcare. The current accepted view of healthcare is of a complicated service which is both art and science best delivered by medical professionals, and is importantly the responsibility of the state to fund and manage. Context and history matter in information system adoption decisions in healthcare. Improving workflow and technology usability may undermine some of the strategies of resistance, but they alone will not ensure compliance and consistent use in the longer term.

The thesis has analyzed the systemization of information in healthcare at a micro level of policy operationalisation to establish a picture of information systems as the means through which reform ideas are diffused into practice. Interviews with key decision makers in healthcare informed a view on the role of information systems in reforming health, and provided an understanding of the effects of reinterpretation of policy in practice within the larger ideological
disputes which exist in the Australian healthcare system. This thesis has sought to describe and 
explain the process of translating policy into practice where information systems have acquired a 
role in reform, within the context of the broader objectives of policy. The transition of health 
discourse from policy to practice in Australia has been characterized by intense negotiations and 
struggle resulting in Australia being the only country in the world to have introduced a universal 
health insurance scheme only to abandon parts of it, to reintroduce it, and to more recently lose 
interest in it again. Health policy making is interlinked with economic, ideological, political and 
social considerations. This thesis is an attempt to provide an analysis of the changing role of 
ideology, politics, economics and social plays in the policy making process. There is no such 
thing as ‘settlement’ in Australia’s health policy setting and while popular support exists for a 
universal health insurance scheme, the evidence suggests political support is waning. Health 
information is assuming a central role in the current transition of health discourse in which 
individuals are encouraged to assume greater responsibility for their own health outcomes and 
resource utilization.

This research is predicated on a combination of historical genealogical tools, the aim was to 
provide a critical account of the evolution of health policy making within a particular socio-
political context. The critical policy analyses pursued in this thesis were achieved by analyzing 
various documents from a combination of sources combined with interview data. The 
overarching concern was how ideas about information were being shaped to support a role for 
the systemization of information in the reform of healthcare. It was argued that policy 
implementation involves negotiation and renegotiation and the unintended consequences of the 
compromises of contestations add to the complexity of attaining future policy outcomes. The 
evidence suggests that compromises made during contestation are difficult to redress. The 
analysis has highlighted: 1) the two system approach to healthcare which has supported the 
dominance of curative medicine: 2) the control gained over a pharmaceutical benefits scheme 
while being unable to subscript doctors to the public service: 3) the provision of a universal 
health insurance scheme without gaining oversight of practice: and 4) the provision of a rebate 
for private health insurers without gaining authority to cap access to publicly funded services. 
The current policy implementation process is suggesting the possibility of: 1) a single system of 
health care delivery for curative and preventative care without gaining authority to speak on the
best way to practice: and 2) introducing a national eHealth infrastructure without gaining end-to-end process reform. This should inform those interested in the effects of policy and those interested in agency and social equity.

To achieve this understanding of policy implementation, the systemization of information in healthcare suggests the role of information systems in support of reform efforts. Described in detail in Chapters 4, 5, and 6 the analysis of the systemization of information highlighted the nature of strategies used to influence policy outcomes. Information ownership as vital to the effective management of healthcare is an idea which has its roots in Commonwealth involvement in setting the direction of healthcare, and was cemented during the disputes of the 1970’s. During the 1990’s this was extended to suggest information ownership as vital to the effective management of quality healthcare, an idea which has shaped the recent reform efforts. Involved in ensuring quality healthcare, information systems have a role in directing the practice decisions made in private enterprises tasked with delivering health services. Steering from a distance, the potential exists for the Commonwealth to influence practice decisions through information systems in a publicly funded fee-for-service model. The institutional structures which support the professions claim to ownership of patient information have been suggested as the existing systemized information structures and notions of privacy linked to confidentiality.

The dual policy focus of responsibly funding a universally accessible public health service, while maintaining a policy of distancing itself from direct service provision, and simultaneously supporting competitive structures, has resulted in seemingly contradictory policies aims. These policy aims tie together ideas about consumer choice in preventative health markets and ideas about quality healthcare as involving self management of preventative risk factors deliverable through the institutional structures which support curative medicine. eHealth is proposed as the tool which would subject the profession to administrative techniques influencing compliance and allowing the Commonwealth to determine the direction of practice. Rather than being driven by a technical imperative for change, the introduction of health informatics is facilitating a power transfer. As a depolitising tool for change, information systems in healthcare, from disease registers to Casemix, have had mixed results. Information systems have not replaced the need to prosecute a case for reform.


7.9 **Suggestions for Further Research**

This study is not a comprehensive study of those involved in health policy, although some insights into the expectations and experiences of different people were gained: there is a need for the point of view of patients, and government policy makers.

**Health Policy studies**

The questions posed in this thesis regarding the potential influences of health information systems indicate a need for more theoretical and empirical research into health policy relating to eHealth. This study has suggested the need to develop a theoretical, critical interpretativist theory influenced framework for the study of health policy. A more theoretical approach to the meaning of health policy, allowing for health policy to be placed within social trends, is an area requiring exploration.

**eHealth studies**

This study suggests the need for further studies focusing on the relationship between eHealth and society, the long-term influence of the implementation of eHealth on health services and the practice of medicine. An immediate area of concern requiring empirical data is to understand the ideas creating tension in healthcare: NEHTA recently postponed the pilot of the PCEHR (NEHTA, 2011, 24th January 2012). This study could be used to generate a set of hypothesis which could be tested quantitatively via surveys sent out to a large number of practitioners. This study provides a jumping off point for research involved in understanding the political interpretations of information systems.

**IS studies**

A complete picture of the systemization of information as a means of diffusing reform ideas would benefit from a longitudinal study which involves a wider range of influentials. This study has suggested the need to develop a theoretical, critical interpretativist theory influenced framework for the study of information systems seconded to the delivery of social goods at a national level. Finally, a more theoretical approach to the meaning of information systems is required. Information Systems as discourse, and the systemization of information as a process
are discussed in this thesis, these concepts could be expanded to explore their utility in facilitating analysis at higher levels of abstraction.
List of Abbreviations

ABS – Australian Bureau of Statistics
AIHW – Australian Institute of Health and Welfare
AMA – Australian Medical Association
APHCRI - Australian Primary Health Care Research Institute
BMA – British Medical Association
BSEG - Broadband Services Expert Group
CHERE - Centre for Health Economics Research and Evaluation
CR - Corporate Respondent
DoHA – Department of Health and Ageing
EHR – Electronic Health Record
GP – General Practitioner
HIPC - Health Insurance Planning Committee
ICT – Information and Communication Technology
IS – Information Systems
IT – Information Technology
MA - Medical Administration
MR - Medical Respondent
NAA – National Archives Australia
NCP – National Competition Policy
NEHTA – National eHealth Transition Authority
NHHRC – National Health and Hospital Reform Commission
NHMRC – National Health and Medical Research Council
PA - Policy Analyst
PCEHR – Personally Controlled Electronic Health Record
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Appendix A – Sample Questions

1. Do you consider the Australian healthcare system to be a well functioning system?

2. What changes would you like to see introduced to the healthcare system? Why?

3. How do you know that the healthcare system is performing well?

4. In your opinion who (which group) has the most accurate picture when describing the overall performance of the healthcare system in Australia?

5. What is driving the current reforms in healthcare?

6. Will the current healthcare reforms be successful? Why?

7. What role(s) do shared integrated Information Systems play in the healthcare system?

8. What role should health information systems play?

9. Who do you believe is driving the use of ICT in the health sector?

10. Why is the Government funding eHealth initiatives?

11. Why has HealthConnect experienced implementation delays?

12. How has the choice of shared integrated systems in the Australian healthcare system been made?

13. Which published performance statistics relating to healthcare do you consider accurately reflects the actual situation?

14. Have advances in information transmission provided improved understanding of decision making in healthcare delivery? If so, how and who has benefited?