

# What If the Four Yorkshiremen Managed Regional Health? Reconfiguring Administration, Management and Leadership in Allied Health beyond the Metropolis

Sue Charlton<sup>1</sup> & Tara Brabazon<sup>2</sup>

<sup>1</sup>Regional Physiotherapist Working at 1 Stop Health – A Multidisciplinary Pediatric Allied Health Practice in Regional South Australia

<sup>2</sup>Professor of Cultural Studies at Flinders University, Flinders University, South Australia

Correspondence: Tara Brabazon, Flinders University, Bedford Park, South Australia.

Email: tara.brabazon@flinders.edu.au

Doi: 10.23918/ijsses.v9i1p393

**Abstract:** This article offers testimony that summons an unspoken and unwritten history of regional Allied Health. Constructed in two sections, this article explores foundational models of Allied Health leadership and then probes the disconnection between these models, strategies, policies and procedures, and the lived experience in regional cities. This research probes the potential of Allied Health services in a regional location, beyond supplementing the agenda of large cities. The aim of this article is to demonstrate what has gone wrong in Allied Health in regional Australia, and then provide tropes and strategies for renewal, particularly after the pandemic.

**Keywords:** Allied Health, Public Health, Regional Health, Health Collaboration, Health Leadership

## 1. Introduction

Certain Monty Python sketches have a life beyond comedy. Eric Idle’s soundtrack for the final scene of *Life of Brian* – “Always look on the bright side of life” – is one of the most popular songs selected for funerals (BBC, 2014). Coconut halves – clapped together to emit a predictable rhythm – signify horses’ hooves and the ludicrousness of King Arthur’s search for the Holy Grail (Monty Python, 2008). Dead parrots hover around pet shops (Cinematheia, 2013). But the sketch that seems to summon, capture and represent the state of administration, management and leadership in health and education, both during and after the pandemic, is the Four Yorkshiremen sketch (The Full Monty Python, 2007).

This sketch has a history that predates Python, through the *At last the 1948 Show* and *I’m Sorry I’ll Read That Again*. Most famously used in the 1974 Monty Python performance *Live at Drury Lane*, and *Live at the Hollywood Bowl* in 1982, Eric Idle, Terry Jones, Michael Palin and Graham Chapman took on the roles, with Palin being the only member of the group who was born and grew up in Yorkshire.

Received: February 14, 2022

Accepted: March 19, 2022

Charlton, S., & Brabazon, T. (2022). What If the Four Yorkshiremen Managed Regional Health?

Reconfiguring Administration, Management and Leadership in Allied Health beyond the Metropolis. *International Journal of Social Sciences and Educational Studies*, 9(1), 393-405.

What makes this skit so resonant is that four affluent men summoned increasingly heightened, brutalized and romanticized renderings of their past sufferings to compete with the sob stories of the other members of their elite club. As the vignettes become increasingly ridiculous, the humour emerges in how the past suffering is expanded to the ridiculous, to puff up the scale of the current success and wealth.

Stories of leadership occupy a similar trajectory. The sufferings of the past are inflated and imagined. The achievements in the present – against the odds and subsidence of earlier practices and assumptions – are heralded and marketed. Lessons are codified and calcified, and then generalized as case studies without attention to divergent histories, industries, professions and contexts. Such patterns emerged before COVID-19. Clearly, leadership in regional allied health has metamorphosed over the past thirty years. Yet the specificity of these struggles and advocacy are masked through a deficit model of regionality and rurality, when viewed through a lens of urbanity. Assumptions about leadership are spread through sectors without detailed attention to local conditions. Describing the changes in leadership since 1992, Boyce states that “effective clinical leadership increases the quality of healthcare service provision and promotes leadership outcomes” (2017). The words in this statement to ponder are “quality,” “provision,” “promotions,” “leadership” and “outcomes.” This article explores how these words dance in management and leadership theory, rarely grounded in the lived reality of Applied Health professionals in regional, rural and remote areas. The function of nostalgia and the imagined creation of a past is harmful to the present and future of Allied Health. The goal of this article is to take stock of this moment – this (post)pandemic moment – and understand how this crisis revealed already existing tendencies of marginalization, deficit and decline in regional health management and leadership.

This article has two goals. Firstly, we offer models of regional, rural and remote health leadership, providing the frame for Allied Health. But then, the second part of this article builds on these models and shows how neglect, marginalization, invisibility and a lack of cross-sectoral collaboration have hampered public health initiatives in regional Australia. Particularly, there is attention on how policy makers and planners in capital cities have undermined and forgotten the earlier history of Allied Health in the regions, often founded on private and public health partnerships, and collaborations between Allied Health professionals and the medical establishment.

## **2. Regional, Rural and Remote Health Leadership**

Rurality, regionality and remoteness are ideologies. All are configured through the gauze of urbanity, with assumptions about population size, service availability and reliability of infrastructure. Rural, regional and remote towns and cities are confronting real challenges and problems. From outmigration, ageing populations, and the loss of health and education services, rural, regional and remote (RRR) locations are confronting myriad economic, social and political challenges. Addressing these multi-phasic issues is often bundled into the word “revitalization” (Williams et al., 2021). Carrying an imperative to reverse rural decline, an array of theories and tropes are used, including sustainability, resilience and learning communities.

The role of leadership in such intricate environments is similarly complex and volatile. Hoping for private or corporate investment – a neoliberal solution - to transform rural environments from decades of neglect has not been successful. As Williams et al confirms, a shift was – and is - required with rural areas

reinvesting through the public good, rather than private interest (2021, p.40). This transformation requires the development of accountability and transparency, alongside cross-sectorial collaboration. The tropes for ‘development’ in the last thirty years have deployed words such as ‘regeneration,’ the ‘fourth industrial revolution,’ ‘resilience,’ ‘social innovation,’ and ‘collaboration.’ These words have been incorporated into neoliberal narratives of efficiency and a shrinking of public services. Yet neoliberalism has cascaded a collapse of rural, regional and remote services to enable efficiency, which is configured and framed by urban metrics. This binarized thinking of urban and rural, metropolis and region, particularly inhibits a recognition of and research into the economic and social diversity and plurality of regional, rural and remote locations. To provide one example of the limitations of this type of thinking:

Cities of today face two choices. Either they develop to meet the challenges created by the pace of global change, or they resist the impulse for transformation and stagnate. At a time when economic systems are no longer predictable, in order to remain competitive, cities are turning to strategies that focus on their own innate resources – their histories, spaces, creative energy and talents (Richards & Palmer, 2010, p.2).

Cities, towns and regions face multiple choices, opportunities and challenges, rather than two options. Further ‘transformation’ or ‘stagnation’ require a degree of investment, autonomy and agency that is rarely seen in regional, rural and remote health care. The policy levers are not in place to enable this freedom or a selection between freedoms. The desire for cities to ‘remain competitive’ means that health and education are neglected. The goal in health and education is not competition or consumerism, but cultural safety and citizenship. The loss or marginalization of these tropes has profound impacts on the areas in our economy and society that rarely create profit but do enable the rest of the economy to function, including the workplace.

As social relations became globalized through the 1990s (Urry, 2003), personal, social and professional relationships similarly transformed. Globalization is a disordering impetus that both reorganizes and compresses differences in identities, geographies and histories. Interdependencies result in widening injustices, most evident in health and education. The cost of globalization – free trade, privatization, deregulation, reduction in public spending and commitments to the welfare state – impacts most strongly on regional, rural and remote regions. Regulation ensures a parity – or at least an attempt at parity – of services beyond metropolitan centres. Without public policy, the convenience and safety of large populations of ‘consumers’ (if not citizens) will remain the magnet for corporations and small and medium sized enterprises.

Leadership and policy instruments are difficult to assemble or develop because, as David Bell and Mark Jayne confirmed, “the woeful neglect of the small city in the literature on urban studies means that we don’t yet have to hand a wholly appropriate way to understand what small cities are, what smallness and bigness mean, how small cities fit or don’t fit into the ‘new urban order,’ or what their fortunes and fates might be” (2006, p.2). Urbanity, rurality and regionality are ideologies. These places and spaces must be made (Tonkiss, 2013). Event management can provide a flash of branding to a location. Of greater difficulty is creating sustainability, both economically and socially. Injustice is created through the unequal infrastructural access.

Beyond the clichés of rural poverty and rural development, regional, rural and remote environments must not be enmeshed into what Robert Chambers described as, “cores and peripheries of knowledge” (2013, 4). Academics are embedded in such binaries. Chambers confirmed that, “for academics, it is cheaper, safer and more cost effective in terms of academic output to do urban rather than rural research. If rural work is to be done, then peri-urban is preferable to work in remoter areas” (2013, p.7). This article, therefore, activates this remedial research to commence discussions about leadership, sustainability and public good.

Agricultural economics necessitates not only an understanding of diverse land uses, but how they change in difficult times, such as through depopulation. With the loss of revenue and depopulation, the loss of public services cascades into the declining support for health and education. To rebuild from this economic reality requires more than regeneration or Key Performance Indicators. Systems must change. To enact this change, a careful auditing of the current economic, social and political reality and possibilities are required. Further, any change must be evaluated, noting that the marginalization of rural areas from urban planning research has depleted not only the good will from citizens, but the capacity to change the emphasis from urban to rural – and the belief in reconfiguring this emphasis.

Therefore, leadership matters in the recalibration of the regional, rural and remote when considering health and education. Administration, management and leadership rarely conflate, yet the adjacent nature of the practices lie to the configuration, transformation or marginalization of systems and structures. Leadership is not ‘about’ personality or a style. It is an organizational position, but it is also relational and configured through interactions and relationship between leaders and followers (Rosenthal, 1997). These leadership interactions configure, reconfigure and maintain ideologies and behaviours. Further, they repress critique and alternatives. That is why the selection of leaders is so crucial to health and educational institutions, and why the masking of hiring processes through ‘executive’ appointment firms and confidential internal processes are so damaging to the credibility of organizations in terms of transparency, but also the capacity to activate diversity in hiring protocols, and alternative views. Allied Health is dominated by women. Leadership is most easily poured into masculine molds (Gurman & Long, 1994). The challenging confluence of masculinity and leadership limits the configuration of “professional capital” (Hargreaves & Fullan, 2012). Post the Global Financial Crisis and the Pandemic, new expectations and requirements are necessary from leadership, including accountability, transparency, expectation management, and the capacity to communicate with diverse cohorts and communities. As Morley confirmed, “quality is audited, equality is not” (2003, p.146). Since Morley wrote those words, neoliberalism has pervaded ‘public good,’ so the very definition of quality has been transformed and displaced by ideologies of market efficiency and profit. Ambition has displaced meaning. Authenticity is lost to KPI-driven achievement. Authentic leadership (George, 2003) is not a style. It is a commitment to integrity, trust and an imperative to not undermine diverse modes of urbanity into normative parameters of compliance.

Organizations can frustrate and exploit people, often carried on a wave of blame and simplification (Bolman & Deal, 2013). Citizenship is confused with consumerism. Public good reifies into commodified transactions (Rutherford, 2007, p.11). This slippage in policy, procedure and outcomes is based on accelerationism, which is, as Benjamin Noys described it, “a political and cultural strategy” (2014, xi) to configure “malign velocities” (2014). The acceleration configures a temporarily and spatially specific

leadership culture that manages threats and risks but delivers on Key Performance Indicators that are disconnected from any theory or application of the public good. Short-termism dominates decision making. Positional leadership ensures that authority is only derived from the occupation of a position. Servant leadership has critiqued this model, with Robert Greenleaf offering this corrective to what he describes as the “low trust culture” of high control management, posturing, protectionalism and adversarial communication systems (1991).

After the pandemic, and the rolling economic crises that both attended and trailed it, commitments to public good through tropes of servant or authentic leadership were challenged. This extreme context meant that the slower and more reflective studies of “leadership style and behaviours” (2019, p. 152) found little place or space in these systems. Indeed, as Hannah et al confirmed, “leadership in dangerous contexts is where effective leadership is indeed needed the most” (2010, 181). The binaries of leadership – leadership / followership, individual / dispersed, hero / plural – agitate and slide. Particularly in health, where models move to “distributed” leadership (Buchanan et al, 2008), “hybrid” (Gronn, 2011), and “plural” leadership (Denis et al., 2012), the pandemic crushed expectations of partnership between public and private healthcare. These traditional dualities shattered in the extreme context of COVID-19. The result of this instability is what Hannah and Parry describe as “complex adaptive leadership” (2014, p.613). Noting that this trope is useable and functional in regional health, we now move to investigate the challenges of Allied Health with regard to maintaining credibility and visibility.

This first part of the article offered models for regional health, aligned with regional development. The second part of this article presents the unspoken and unwritten history of Allied Health, through the lens of Australian regions. Sue Charlton, one of the co-authors of this article, deploys her fifty years of experience to understand the history and trajectory of Allied Health, but also the missteps in leadership that are now – post-pandemic – demonstrating a toxic dividend.

### **3. Allied Health: History and Trajectory**

Allied Health, through its many definitions, exists in an ambiguous space around terms and fields such as primary health care, public health, and medicine. The ‘Allied’ in Health confirms a relationship or an alignment with already existing medical professions, disciplines, parameters, diagnostic tools and treatment options. Significantly, Allied Health is composed by women-dominated professions that emerged nearly a century after the credentialing and professionalization of medicine, as demonstrated through the configuration of university degrees and professional associations. Yet Allied Health is significant, particularly in the construction and application of fairness in access to preventative health measures and strong outcomes. Fairness is not determined by those in power, but is crucial to those without power (Dorling, 2016). For example, both physiotherapy and occupational therapy are integral to pediatric medicine, disability support and palliative care. For the young, the old, and the dying, Allied Health provides a suite of support structures to enable the living of a life, through obstacles, challenges and impairments.

The administration, management and leadership of allied health tells a different story, divergent from this portfolio of care. Managed under the medical model in the 1990s, where the medical superintendent chaired the management board with no allied health representation, it was a diffuse system varying in

availability of services according to individual knowledge about the benefits of allied health intervention. Allied health services largely comprised Physiotherapy and some Occupational Therapy. It was more likely to be available in adult services with lesser availability in paediatric services.

Dr Sue Charlton, one of the authors of this paper, has viewed the management of physiotherapy services between 1966 – 2021, both in the public sector and privately. She has lived the changing trajectory of Allied Health. At the time of graduating with a diploma in physiotherapy, physiotherapists were able to provide services to patients on referral from a medical practitioner. Such referrals described the condition of the patient and requested exactly what services were to be provided. Any variation to services required agreement from the referring doctor before instituting any change to the treatment. On return to the referring doctor, a detailed outline of the treatment given and the patient response to that treatment was required. Treatment was then continued if the doctor decreed that it should be. As the referring doctor gained confidence in the physiotherapist, there was more leniency about adjustments to treatment with better opportunity to offer recommendations for adjustments based on physiotherapy assessment. There was a minimal medical benefit payment for those who had extras cover in their scheme. This benefit was only payable for the provision of private physiotherapy when the patient was referred and managed by a doctor.

From this foundation, access to – and the creditability granted to – allied health increased. The Australian Physiotherapy Association promoted the training and ability of Physiotherapy graduates to assess and monitor patient progress and to be included in more open discussions of the benefits and concerns about physiotherapy treatment. In particular, the Association argued for a patient's right to access physiotherapy by choice rather than by referral. Although this change was made, there was still no place for an allied health person to be included on management boards of hospitals and health services. The change in access to services through the 1980s caused a shift in the purchaser/provider split, where the purchaser had increased ability to choose the services they required and to select frequency of access. At the same time, it increased service contestability, as the freedom to choose highlighted the services which patients found more accessible and more responsive to their needs. These choices led to financial and policy changes in the National Health Strategy Unit as reported in 1991 and 1993. Management and financial control became the responsibility of clinical units rather than the centralized system which had prevailed. The New Public Management team was led by a primary medical clinic manager with more emphasis on patients rather than products.

#### **4. Management Changes**

For Allied Health, this led to the implementation of divisional structures and the development of clinical units in public hospitals. This shift catalyzed the clinical supervision of allied health services in public hospitals. Opportunity was available for the management of resources as well as service delivery. This new model was tested and instituted in two regional centres: The Queen Elizabeth Centre in Ballarat as described by Baum (1995), and the Whyalla Health Service (Nihill, 1992). However, various forms of management existed across the continent of Australia.

- The medical model persisted in some health services.

- An Allied Health representational model where a revolving allied health chair was appointed from all AH groups such as physiotherapy, occupational therapy and speech pathology.
- AH model where the director of AH was included in the medical model
- AH directors/managers sat in a free-standing division reporting to CEO or CSM.
- Unit dispersant model where individual professions dispersed financial amounts as clinical units. Thus, overall AH budget divided between all AH services in a bargaining style system

With these diverse models in play, discussion emerged in the evaluation of the optimum management system. With an emphasis on budgetary control, priorities shifted from patient service to economic accountability. If this accountability was to be the frame for all other decisions, then this outcome may be best achieved when each branch of Allied Health justified its own budget and managed within that limitation. Where there is bartering between branches of Allied Health in each budget, it can be difficult to maintain a continuity of service and forward planning for staffing and professional development.

The specificity of rural and regional health must also be acknowledged. In rural and regional health services, there is an opportunity for individual services to work more collaboratively, mindful of the particular skills of each Allied Health specialty. This collaboration can activate a saving of time and resources if there can be some overlap of supervision of individual clinical programmes. A visiting Allied Health professional can check individual client progress and inspire the continuation of a programme within the understanding that changing the programme requires suitably qualified professional expertise from the prescribed allied health worker. Most Allied Health professional bodies favour the free-standing model of management and service provision. Managing the purchaser/provider split has led to debate about service provider agreements or internal contracts to gain a stated outcome for a set figure. In tertiary centres, debate about optimum management systems have continued, and a move to increased management positions has become a career path for some allied health workers. This movement into management has occurred too in some rural and regional centres, but at the expense of clinical staffing where recruitment and retention of staff has become increasingly difficult.

### **5. Changes in Regional Health: A Narrowing of Purpose**

A wise if clichéd mantra is that it is fine to glance over our shoulder, but we should not stare. History is important, but as confirmed by our opening Four Yorkshiremen narrative, this past can be inelegantly recalibrated for the purposes of a volatile, ideological and narrowed present. The transformation of Mount Gambier's health services into one large regional centre in South Australia will serve to reveal some of the difficulties which have been seen in both management and recruitment/retention of professionals. In the early 1970s, the Mount Gambier regional hospital was a 200-bed institution with an attached residential nurse's home, encasing nursing staff from across the region. Nursing training was delivered through an apprentice mode, with nurses of all levels working on each ward. There was a matron, who visited every inpatient each day, knew all nurses by name and offered advice and encouragement to all staff. Nursing was an intensely hierarchical system with each person knowing their role and responsibility. There was a requirement for nurses to complete periods of their training in tertiary units in Adelaide. Nursing was considered a good occupation for young women to pursue, without the need to move to a capital city for further education, except for the short stints required throughout their course. Nurses trained in this way were most likely to continue to work in the regional or rural area upon graduation, although the more

adventurous, having worked in a larger city, sought to pursue further training in specialist areas and moved to the city.

The medical services were provided by the local general practitioners and specialists who worked in their own practices in the region. There were two large medical practices with both specialists and general practitioners forming the partnerships in these practices. The practice had several GPs, an ENT surgeon, a gynecologist, an orthopedic surgeon, and a general surgeon. All had admitting rights at the hospital and were able to use the operating theatres. Some of the GPs had anesthetic training. Some were GP obstetricians. All medical services, both public and private, were provided by the local doctors, with no salaried medical staff in the hospital. All partners in the practice were part of the duty roster for out of hours' general medical care.

The hospital functioned on a fee-for-service basis with the local doctors. Prior to the introduction of Medicare, pensioners were treated free of charge. This meant that some days when providing anesthetics for the local surgeon, both the GP and the surgeon would receive no remuneration for the day's work. Very often they would receive a jar of jam, some meat, fish, or homemade cakes from the patient on their return home. Upon discharge, patients returned to consult their doctor in their chosen General Practice, who provided follow-up management and surgical supplies as needed. The medical superintendent of the hospital was one of the local doctors and he was required to meet regularly with health officials from the Hospitals Department in Adelaide to discuss budgets and staffing of the regional hospital. He was able to advocate for changes to staffing at the hospital. There was no physiotherapy or other Allied Health department in the hospital. A limited physiotherapy service was provided by a local practitioner when he was advised that it was required.

Mount Gambier is an important – and incisive – example because it is distanced from capital cities and has sustained a strong population base. Indeed, the population served by health professionals was greater than many suburbs of Adelaide, the capital city. Both Modbury and the Lyall McEwin Hospitals had established physiotherapy departments, providing inpatient as well as outpatient services. Accepting that there were no outpatient services at the Mount Gambier Hospital at this time, it was felt that there should be a more comprehensive inpatient service available. At this time, the Mount Gambier Hospital had a medical unit with attached rehabilitation beds, surgical, paediatric, maternity wards, as well as an intensive care unit. The medical superintendent supported the claim for some established physiotherapy hours to formalize and expand the services offered. A more comprehensive service commenced in 1994. Although there was still no physiotherapy department, several local practitioners were able to provide adult and paediatric services to inpatients on an “as needs” basis.

The building of a new hospital in 1997, combined a Community Health Service and the Hospital in one building which included an Allied Health wing providing both outpatient and inpatient services. There were two large areas, one for Occupational Therapy and one for Physiotherapy. Seniors of both disciplines were appointed with co-ordination managed by the previous domiciliary care manager. A Speech Pathology service was commenced and there was an increase in visiting specialists from metropolitan Adelaide.



## **6. Recruitment and Retention in Regional Allied Health**

Problems with recruitment and retention of Allied Health personnel have been an ongoing problem, causing difficulty with consistency of staffing of these departments. Regional, rural and remote 'churn' of staff is common in both health and education. The hierarchical management of the regional health service which developed has contributed to these difficulties. Staffing was largely controlled through the central health department in Adelaide and the role of medical superintendent became less autonomous. Local service meetings were held where professionals made recommendations about their services, but funding and staffing were centrally controlled. Allied health departments vied for funding and client numbers, rather than operating a collaborative allied health unit. One representative from Allied health sat on the management board and the strength of that person was a mark of how the department operated.

Research has shown that professional development and position advancement is paramount in the maintenance of allied health workers in rural and regional Australia and what has been seen in regional South Australia exemplifies this maxim. Maintaining the top positions in allied health departments has vacillated between those who came in prepared to fight for better funding and better work opportunities and those who became disheartened as they saw that their voices were not heard and there was little opportunity of developing strong forward moving units. Funding was the major concern. Some senior therapists became disillusioned with the continual battle while others were content to accept a more resigned role and accept leadership without pursuing opportunities for development. Some departments flourished while others stagnated.

In writing about leadership in Allied Health, Althausser and Appel described the need for systems which relied on education and credentialing leading to financial and status competition (Althausser and Appel, 2000). Such systems could not only lead to consistent leadership, but also offer a pathway for professional advancement. However, Keane et al. (2013) found a stronger tendency for older staff members to remain in rural and regional positions, rather than more recently graduated allied health workers. Such senior staff, holding management positions, are more likely to remain in the position for longer, being often well-settled in their family and environment. Emphasis must be placed on planning to accommodate future needs and progression for junior staff to maintain their expertise and enthusiasm for advancement.

## **7. Influences in These Management Transitions**

The movement toward evidence-base (EBP) in practice was expanding with the work of Archie Cochrane (1973). Randomized controlled trials (RCTs) were used to inform clinical practice, providing evidence of efficacy and effectiveness. Human resources and capital expenditure were also factors, although many RCTs were conducted across large metropolitan tertiary centres with little consideration for the way that regionality may impinge on outcomes. The sourcing and employing of EBP and RCTs was incorporated into medical teaching, with Sackett developing a master's degree, built on literature reviews and critical appraisal. Subsequently, this became included in clinical healthcare workplaces.

An interest developed in problem-based learning rather than the traditional systems learning and, in many centres, medical training changed dramatically. The combination of EBP, literature reviews and critical appraisal led to the development of clinical guidelines and this system moved out to nursing and allied

health training as well. This system was of considerable interest to managers, for budget and finance. It became a tool for policy makers as well, producing a linear process of decision making and funding. Clinical guidelines, based on EBP and systematic reviews informed funding and heralded the implementation of Casemix funding for hospitals, with length of stay and treatment parameters based on diagnosis, according to the funding policy and not necessarily the patient state. It detracted from the logical process of clinicians and personal patient preferences being considered. Treatment was more guided by managers who controlled the funding, and policy makers who determined the typical pathway for treatment according to clinical guidelines and EBP. An element of political saliency crept into decision making, with much attention being placed on levels of care in hospitals and regional services. It became clear within regional health that patient preferences and local priorities and resources should be given more consideration in the formulation of clinical guidelines and thereby included in management and policy discussion, making such decisions more inclusive and less linear.

### **8. Centralization versus Regionalization**

From the rendering of this history, leadership had moved from local regional leadership to more central, metropolitan control in South Australia. What commenced as local management by local hospital and health boards merged to become a State-based organization named SA Health. A further alteration in leadership occurred in the 1970s when the two major health organisations in South Australia were combined into one State Health Department. Prior to this there had been a Health Department and a Hospitals Department. The Health Department was responsible for the health of the public, working on disease prevention and eradication, vaccination programmes and community wellbeing. The Hospitals Department managed the funding and running of the hospitals across the State. The Health Department was State Government funded while the Hospitals department attracted more Federal Government funding. The merging of these two major health departments has seen a growth in hospital services with a reduced attention to preventative health and community responsibility for health.

A widening disparity between central and regional health developed, with increasing difficulty in attracting and retaining health workers in regional and remote areas in the State. The National Rural Health Strategy developed in 1994 strove to address this problem. Nationally, over one third of the population lived outside the capital cities in Australia. The per capita medical spend via Medicare was markedly lower per head in rural and regional Australia. This was in part due to the lower numbers of practices which provided bulk-billing facilities for their patients compared to metropolitan practices. The patient/doctor ratio was also much higher in rural and regional practices, making it more difficult for patients to get an appointment.

John Wakeman and associates (2008) suggest that knowledge has been gained through the National Rural Health Strategy since 1994. Services have been enhanced and implemented. He does however recommend that, “community agencies be represented on Boards, providing professional business management,” including a recognition of local expertise. In a study conducted between 2009 and 2014, it was determined that neo-liberalism lowered the comprehensiveness of Primary Health Care while at the same time increasing the cost. Baum claimed changes were brought about by:

less comprehensive service coverage and more focus on clinical services and integration with hospitals and much less development, advocacy and intersectoral collaboration and attention to social determinants. (Baum, 2016)

Such behaviours discourage local management and provide little consideration of local knowledge and health expectations.

In South Australia, there has been an attempt to broaden health management by once again changing the structure of SA Health. The public health system is divided into ten Local Health Networks, each with its own management board, answerable to SA Health. There are four LHN's in metropolitan Adelaide and environs, one being the Women's and Children's Hospital which manages pediatrics statewide. The remaining six networks cover the rest of South Australia. Local Health Networks are responsible for the overall governance and oversight of local service delivery. They must report to SA Health and funding is allocated through SA Health. Leadership becomes a significant concept when contemplating this structure, which somehow seems a little remote from the local healthcare workers.

In reading the responsibilities of the Local Health Network, they manage local health service delivery, contribute to and implement system wide plans issued by the Department of Health and Wellbeing. The LHN must meet KPIs, all centrally devised. These obligations would seem to represent a top-down type of leadership which requires an open attempt to conduct local discussion groups and opportunities for input from both health workers and consumers in each region to afford the opportunity for local discussion. There is a variation in funding and availability of services between LHNs with a sense of competitiveness prevailing. Speculation about funding heightens as elections approach. It then ebbs when new governments enter office.

## **9. Conclusion: A Recognition of Place and Expertise**

Covid-19 has demonstrated the consequences of imposing the parameters and policies in large cities on the regions. Assumptions about the availability of Allied Health professionals, alongside required equipment to manage a pandemic, were disastrous to public health. Decades of neglect have resulted in a broken regional health system. Effective partnerships and collaborations – and good will – have been exhausted. These inequalities and errors have many causes. One is the urbanization of the nation of Australia. Another is the sourcing of political leaders from the major capital cities. But most importantly, these errors and missteps have been caused by a failure of leadership. The lack of gumption, courage and connected thinking has impacted on all areas of public health. However, Allied Health, which was late to gain professional organizations and national and international credentialing, has been most effected.

COVID-19 demonstrated the false dichotomy between health and financial concerns. When health is neglected, risked and marginalized, all other areas of the economy suffer. This article has offered firsthand testimony of an unheard history of regional Allied Health. This article has been constructed as a warning, but also as a hope. It has recently been reported that COVID-19 has signaled a strong migration from capital cities to regional areas (Stephens, Cansdale and Forbes, 2022). As this population moves, their expectations about health provisions migrates with them. Like the Four Yorkshiremen, wistfully

remembering a past that never existed, disappointment awaits them in the present. Until Public Health 'leaders' revision a regional future, diversity, plurality and social justice will be bled from the body politic.

## References

- Althausen, R., & Appel, T. (2000). *Generating social stratification*. London, Routledge.
- BBC (2014) Monty Python Tune tops funeral songs. <https://www.bbc.com/news/entertainment-arts-30143250#:~:text=Monty%20Python's%20Always%20Look%20On,the%20preferred%20choice%20of%20music>
- Bell, D., & Jayne, M. (2006). *Small cities: Urban experience beyond the metropolis*. Abingdon. Routledge.
- Bolman, L., & Deal, T. (2013). *Reframing organizations: Artistry, choice and leadership*. San Francisco: Jossey-Bass.
- Buchanan, D., Addicott, R., & Fitzgerald, L. (2007). Nobody in charge: Distributed change agency in healthcare. *Human Relations*, 60(7), 1065-1090.
- Buchanan, D., & Hallgren, M. (2019). Surviving a zombie apocalypse: Leadership configurations in extreme contexts. *Management Learning*, 50(2): 152-170.
- Chambers, R. (2013). *Rural development: Putting the last first*. Abingdon. Routledge.
- Cinematheia (2013). Monty Python Dead Parrot. You Tube:  
<https://www.youtube.com/watch?v=vZw35VUBdzo>
- Denis, J., Langley, A., & Sergi, V. (2012) Leadership in the plural. *The Academy of Management Annals*, 6(1),1-73.
- Dorling, D. (2016). *A better politics: How government can make us happier*. London. London Publishing Partnership.
- Full Monty Python (2007). The Four Yorkshiremen, You Tube:  
<https://www.youtube.com/watch?v=ue7wM0QC5LE>
- George, B. (2003). *Authentic leadership: Rediscovering the secrets to creating lasting value*. San Francisco. Jossey-Bass.
- Greenleaf, R. (1991). *Servant Leadership: A journey into the nature of legitimate power and greatness*. Mahwah. Paulist Press.
- Gronn, P. (2011). Hybrid configurations of leadership. In A. Bryman, D. Collinson and K. Grint eds, *The Sage handbook of leadership*. London. SAGE: 437-454.
- Gurman, E., & Long, K. (1994). Work role identity and leadership behaviour. *Journal of Psychology*, 128(4)
- Hannah, S., Campbell, D., & Matthews, M. (2010). Advancing a research agenda for leadership in dangerous contexts. *Military Psychology*, 22: S157-S189.
- Hannah, S., & Parry, K. (2014). Leadership in extreme contexts. In D. Day (ed.), *The Oxford Handbook of leadership and organizations*. Oxford. Oxford University Press: 613-637.
- Hargreaves, A., & Fullan, M. (2012) *Professional capital: transforming teaching in every school*. New York: Teachers College Press.
- Monty Python. (2008). You're using coconuts. YouTube:  
<https://www.youtube.com/watch?v=3XPnIUtcANg>
- Morley, L. (2003). *Quality and power in higher education*. Buckingham. Society for Research into Higher Education and Open University Press.
- Noys, B. (2014). *Malign velocities: Accelerationism and capitalism*. Alresford. Zero Books.
- Richards, G., & Palmer, R. (2010). *Eventful cities: Cultural management and urban revitalization*. Amsterdam. Elsevier.
- Rosenthal, C. (1997). A view of their own: women's committee leadership styles and state legislatures, *Policy Studies Journal*, 25(4)

- Rutherford, J. (2007). *After identity*. London. Lawrence and Wishart.
- Stephens, R., Cansdale, D., & Forbes, L. (2022). Migration from cities to regional areas doubles during Covid,” ABC News, <https://www.abc.net.au/news/2022-02-18/migration-from-cities-to-regional-areas-doubles-during-covid/100839386?fbclid=IwAR0BhrELtSixH0LFFv--OPVefeoYfQJubZtyK8LIbCB7JM97TKpt8WffzVE>
- Tonkiss, F. (2013). *Cities by design: The social life of urban form*. Cambridge. Polity.
- Urry, J. (2003). *Global complexity*. Cambridge. Polity.
- Williams, J., Chu, V., Lam, W., & Law, W. (2021). *Revitalising rural communities*. Singapore, Springer.