Developing a Collaborative Rural Health Service Identity: 
A Grounded Theory Study of the Development of 
Multi-purpose Services in Rural 
New South Wales

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Certificate of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Name: Judith Anderson

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Date: 25/03/2010
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Ethics Approval

This research involved human participants. Ethical approval was sought and provided by Charles Sturt University and Greater Western Area Health Service. Copies of letters of approval from both these committees are included in Appendix 1. The reference numbers were:

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Professional editing was limited to formatting, grammar and style (Australian Standard for Editing Practice – ASEP Standard D – Language and Illustrations, ASEP Standard E – Completeness and Consistency) and did not alter or improve the substantive content or conceptual organisation of the thesis. This assistance was provided by Di Davies. A fee was paid for this service from personal funds.
Abstract

The overarching purpose of this study was to construct a grounded theory describing the social process of developing a collaborative health service identity in rural Australia. Specifically, the study focused on the experience of participants involved in the development of multi-purpose services in New South Wales. A review of the literature demonstrated that while some research had been undertaken in the amalgamation of services, very few studies have taken place in health or rural Australia, or have included the perceptions of community members. This research aimed to develop an understanding of the process involved in the development of a collaborative health service identity to inform guidelines and recommendations of how best to implement such strategies in the future.

Thirty participants were interviewed for approximately one hour and asked to describe their involvement in the development of multi-purpose services. All interviews were audio taped, transcribed verbatim and analysed using grounded theory. In keeping with grounded theory, analysis of each interview was carried out before the next interview was conducted.

Data analysis led to the identification of three phases which form the basis of the interpretive chapters of this thesis. The first represents the drivers of the basic social process which leads to the development of the multi-purpose service. This is followed by the engagement of stakeholders which forms the second phase. The outcomes of this process are identified as the third and final phase. This involves changes in service
delivery, the physical structure of the new multi-purpose service and the degree of integration which is achieved. A core category, Anticipation of Risk, links the phases together, as participants describe this to be their main concern in the development of a collaborative rural health service identity.

This substantive grounded theory has implications for managers, community engagement and future research as it describes change in a rural Australian context. The importance of valuing the input of all participants in a situation of change is stressed with the benefits of trusting and suspicious participants being a significant feature of the core category of anticipating risk.
CHAPTER 1. INTRODUCTION

A multi-purpose service is an integrated health service, combining acute care, aged care and primary health care. The Multi-purpose Service Program began in 1991 as a solution to health problems being experienced throughout rural Australia. These problems included poor health outcomes in comparison with their metropolitan counterparts, difficulty attracting staff and a lack of viability and range of health services in rural areas. Large variations in rural population numbers created major differences in the needs of rural communities and their ability to sustain individual health services (Sach & Associates, 2000; Hoodless & Evans, 2001; National Rural Health Alliance & Aged and Community Services Australia, 2004).

This chapter introduces the current study providing an understanding of the contextual environment of the participants and their experiences. It highlights the situation of rural health in Australia, discussing issues of rurality and the financial context which have impacted on the development of multi-purpose services in New South Wales. A brief history of multi-purpose services including a definition of this model of health service delivery provides a background to ensure that participant comments are better understood. The unique context in which the multi-purpose service model was created is described to establish why the present study was undertaken and to establish the significance of this research. An outline of the research aim follows together with an overview of the methodology being used in the study. Finally an overview of the thesis is presented.
1.1 Context

The geographic context of the present study was that of rural New South Wales, where the Commonwealth and State Governments jointly implemented the multi-purpose service model of health service delivery. A brief background of contextual issues related to rurality, financial issues and model of health service delivery will be discussed in order to clarify their impact on the current study.

1.1.1 Rural Context

The multi-purpose service model was developed jointly by the Commonwealth and State Governments of Australia to address rural health problems (Multipurpose Services Taskforce, 1991; Australian Government Department of Health and Ageing, 2004). The health of people living in rural Australia is generally worse than their metropolitan counterparts (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Australian Institute of Health and Welfare, 2005; Greater Western Area Health Service, 2007; Independent Pricing and Regulatory Tribunal, 2008; Wakerman & Humphreys, 2008). Poor rural health is related to socio-economic disadvantage, shortage of health care providers, poor personal health management, greater exposure to injury risks, lack of public transport, poor road quality and geographic isolation (Strasser, Harvey, & Burley, 1994; Hartley, 2001; Lewis, 2004; National Rural Health Alliance & Aged and Community Services Australia, 2004; Greater Western Area Health Service, 2007). Other than poor health, issues related to the rural context which impact on the development of multi-purpose services include defining rurality, the
ageing population, the rural workforce and, in New South Wales, recent restructuring of the health service.

In order to clearly define rural and remote areas, several classification systems have been developed, including the Rural and Remote Area (RARA) classification system, the Accessibility Remoteness Index of Australia (ARIA) and the Rural Remote Metropolitan Access (RRMA) classification system. No one classification system is clearly acknowledged as addressing all the issues related to rural and remote health (Lewis, 2004; Skela Savič, Pagon, & Robida, 2007; Francis & Chapman, 2008; Wakeman & Humphreys, 2008). Instead it is acknowledged that rural areas are difficult to define and vary greatly, not just from one another, but also seasonally, leading to an expression of different needs at different times (Humphreys, 1998). In order to meet such a variety of needs, health services must be unique for each community. When deciding what health services are appropriate for rural communities, several factors need to be considered, including their populations, proximity to more sophisticated health services (including the capacity of retrieval services), availability of support services and staff profiles (Reid & Solomon, 1992; Wakeman, 2009). These factors alter over time, some even vary seasonally such as a population which is influenced by seasonal work (e.g. harvesting) and proximity to other health services which may vary due to weather conditions (Humphreys, 1998).

Rurality is frequently associated with a culture of self-reliance, hardiness, stoicism, conservatism and independence, which lead to infrequent reporting of unmet service needs (Strasser et al., 1994; Wilkes & White, 1998; Congdon & Magilvy, 2001; Forrest,
Alston, Medlin, & Amri, 2001; Wakerman et al., 2008). These cultural features distinguish the rural population from that of metropolitan Australia and suggest the need for specific research rather than generalising from research which has been undertaken in metropolitan areas.

The Australian aged population is growing and this is not limited to metropolitan populations (Hugo, 2002; National Rural Health Alliance & Aged and Community Services Australia, 2004). The majority of older people prefer to age in their own home or at least within their own community (National Rural Health Alliance & Aged and Community Services Australia, 2004; National Rural Health Alliance, 2009). For those older people requiring assistance residential aged care is provided with minimal assistance in hostels (low-level care) and greater assistance in nursing homes (high-level care). Capital cities have more hostel places per capita of population than rural and remote areas, and nursing home availability also decreases with increasing remoteness (Scott, 2003; National Rural Health Alliance, 2009). The older person in general is articulate and politically aware. They have been developing lobby groups, such as the Pensioners’ Action Group, and influencing public policy, making an impact on aged care standards (Scott, 2003). Together these changes have had an impact on the type of health care required by the ageing population in the rural environment, which could be addressed through the multi-purpose service model.

The majority of Australia’s population and workforce are urban, leading to a predominance of urban health services (Bourke et al., 2004; Lewis, 2004; Struber, 2004; Fleming, 2008). There continues to be an undersupply and maldistribution of health
professionals outside metropolitan Australia (Humphreys, Jones, Jones, & Mara, 2002; Struber, 2004; Healy, Sharman, & Lokuge, 2006; Garling, 2008; Independent Pricing and Regulatory Tribunal, 2008). Those staff members who are attracted to working in rural health are also rarely prepared to provide the diversity of health care required by a small community (Bourke et al., 2004; Lewis, 2004; Struber, 2004; Fleming, 2008). This diversity of staff leads to an assortment of qualifications and interests among the health professionals available in each small rural community. This variety inhibits the ability and desire of health professionals to conform to formulaic models of health service delivery (Struber, 2004).

The specific rural context of the present study was that of New South Wales. In New South Wales multi-purpose services (and the small rural hospitals which preceded them) are controlled by the local area health service. On March 16, 1996 rural area health services were restructured, amalgamating 23 district health services into eight rural area health services (Stewart, 1996). The 1996 restructure was followed on January 1, 2005 with a state-wide (rural and metropolitan) amalgamation of area health services which resulted in the reduction of those eight rural area health services into four (NSW Department of Health, 2005). This restructure was undertaken to produce administrative savings, improve the purchasing power of area health services, redistribute health resources to those areas which had the greatest need for them (Garling, 2008) and has led to a centralisation of power (Skinner, Braithwaite, Frankum, & Kerridge, 2009). Such continual change and restructuring are often seen as being chaotic and may lead to declining trust (Baum, 1999; Greenhill, 2006; Blake et al., 2008; Doolan, Mills, & Francis, 2008; Marshall, 2009) or ‘restructure fatigue’ (Garling, 2008, p. 1058). At the
locations from which participants in the present study were recruited, a further change had been introduced as they were also involved in the development of a new model of health service delivery – the multi-purpose service.

1.1.2 Financial Context

Australian health care services are provided by a complex combination of Commonwealth and State Government funding. The federated system of government created a division of government responsibilities where the Commonwealth manages the welfare budget (including aged pensions, nursing home subsidies, medicare) while the State is responsible for the public hospital system (Scott, 2003; Nicoll, Jackson, Then, & Matyk, 2004; Doolan et al., 2008). This arrangement inhibits movement of funds across program boundaries, creating service fragmentation and duplication (Brookcor Consulting, 1998; Lewis, 2004; Healy et al., 2006; Independent Pricing and Regulatory Tribunal, 2008). The New South Wales Department of Health indicates that the division between Commonwealth and State roles presents an ongoing challenge which increases the overall cost of health (NSW Department of Health, 2007). This current arrangement of multiple funding bodies provides financial incentives for health care services to shift costs from one funding provider to another in a manner which does not always provide optimal health outcomes (Multipurpose Services Taskforce, 1991; Healy et al., 2006; Independent Pricing and Regulatory Tribunal, 2008; Wakerman, 2009).

In the broad Australian context economic rationalism has been a dominant political feature for several decades. It includes policy directions of low debt, reducing public
expenditure and improving efficiency through funding cuts. In health care services economic rationalism has led to casemix-based funding (Brookcor Consulting, 1998; Evans, Han, & Madison, 2006; Doolan et al., 2008). These policies have resulted in reduced choice of services and tenuous funding for services for the rural population which frequently leads to public cynicism and distrust of politicians (Baum, 1999, 2008; Doolan et al., 2008). Despite these policies, health care costs continue to rise (NSW Department of Health, 2007; Independent Pricing and Regulatory Tribunal, 2008) and the New South Wales Department of Health (2007, p. 9) specifically acknowledges its need to “operate within the budgets available [and] this will require difficult decisions about service priorities including service realignments”.

The Multi-purpose Service Program was introduced during this time of sweeping economic reforms and aimed to more appropriately meet the needs of local communities (Brookcor Consulting, 1998; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Durey & Lockhart, 2004; Evans et al., 2006). When faced with this history of decreasing public expenditure it is not surprising that some small rural communities interpreted the new model of health service delivery as a reduction in health services. The viability of a small rural community often hinges on its health service as a major employer within that community. Possible loss of employment within health services could have a destabilising effect on the entire community (Reid & Solomon, 1992; Keating & Calder, 1997; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Sach & Associates, 2000; O’Toole, Nesbitt, & Macgarvey, 2002).
The Commonwealth with its responsibility for aged care determines bed allocations for hostels and nursing homes. In the past some of these allocations were in numbers now considered to be unviable (National Rural Health Alliance & Aged and Community Services Australia, 2004). These low bed allocations have placed additional pressure on many small rural communities which built hostels and nursing homes that they believed to be sustainable and capable of addressing their future needs.

Multi-purpose services receive Commonwealth funding for flexible aged care places (the service determines the level of care required e.g. community, hostel, nursing home) and State funding for a range of other health services (Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). Multi-purpose services also frequently attract State funding for capital works, but the availability of this funding varies within each State and Territory (Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). The majority of funding for multi-purpose services is provided by the State (Nicoll et al., 2004). The power associated with this funding ensures that State-funded health services can maintain their control of the newly developed facilities if they desire and in New South Wales this is the case (Andrews, et al., 1995).

The interaction of the rural context, an innovative model of health service delivery and a complex financial context all impact upon the development of multi-purpose services in rural New South Wales. The health issues of rural Australia need to be addressed and the multi-purpose service model with its focus on integration and primary health care attempts to do so. The multi-purpose service model allows the pooling of funding from
both Commonwealth and State Governments to address financial issues specific to rural health in Australia. Four government reviews (Andrews, Dunn, Hagger, Sharp, & Witham, 1995; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Sach & Associates, 2000; Nicoll et al., 2004) have been carried out to assess how well the multi-purpose service model functions. However, the implementation of the change itself has not been studied and the perspectives of participants and their impact on the change have not been described.

1.1.3 Model of Health Service Delivery

The traditional bed-based model of health service delivery has come under pressure with rising costs and shorter hospital stays. Greater emphasis is being placed upon service integration, improved productivity and efficiency (Brookcor Consulting, 1998; Lewis, 2004). Rural hospitals service small populations which leads to low patient numbers; this impacts on the ability of staff to maintain their competency in some areas, leading to a greater transfer of patients to larger services (Lewis, 2004). A multi-purpose service model of health service delivery emphasises funding flexibility and service integration (in particular, primary health care, acute care and aged care) (Department of Human Services (Vic), 1996b; Brookcor Consulting, 1998; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002).

The multi-purpose service model being studied in this research superseded a more limited multi-purpose centre concept (Multipurpose Services Taskforce, 1991; Reid &
The Multi-purpose Centre Program began in 1989 for small isolated communities which were threatened with losing hospitals and related health services (Multipurpose Services Taskforce, 1991; Humphreys, Mathews-Cowey, & Rolley, 1996). The multi-purpose centre model was designed to bring together at least three different health or aged care services (at least one of which was to be funded by the Commonwealth Department of Health, Housing and Community Services) sharing administration, physical location and coordination (Multipurpose Services Taskforce, 1991; Humphreys et al., 1996; Bidwell, 2001). Individual services within multi-purpose centres received their funding exactly as they did previously although coordination of the services was assumed by the new multi-purpose centre operator (Multipurpose Services Taskforce, 1991; Humphreys et al., 1996). Multi-purpose services are similar to multi-purpose centres but extend the model by including at least one aged care service and having provision for pooling funds which allows them to be used more flexibly (Bidwell, 2001). Funding for aged care, in particular, is flexible: it is paid, not according to the level of care provided to residents (as in hostels and nursing homes), but as a ‘cashed out’ model based on the number of places which have been approved for the multi-purpose service. This flexibility allows the multi-purpose service to determine how best to meet community aged care needs (Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). Chapter Two will review literature related to multi-purpose services, including a description of the model, how it came about and what evaluations have been undertaken.
1.2 Area of Study

Due to the unique nature of each multi-purpose service, which is required to address individual rural community needs, the successful roll out of multi-purpose services is dependent on people involved at the local level. Developing a multi-purpose service requires a significant change in organisational culture and financial management to adapt to the new model of health service delivery. For managers, developing a multi-purpose service can involve using markedly different skills to those they use on a daily basis. Incomplete understanding of the context in which multi-purpose services were proposed can potentially threaten their future success.

Funding for the initial pilot program of multi-purpose services was approved in 1991 (Sach & Associates, 2000; Hoodless & Evans, 2001; National Rural Health Alliance & Aged and Community Services Australia, 2004). In New South Wales the rural towns of Baradine, Urana, Urbenville and Braidwood were formally approved as pilot sites in 1993 (Andrews et al., 1995). Benefits from the multi-purpose service model are described as taking a minimum of two years to become apparent (Sach & Associates, 2000; Evans et al., 2006) and time from conception to commissioning is usually a minimum of two years also. Extrapolating from these dates, benefits from the Multi-purpose Service Program would not have been apparent until at least 1997 and at that stage only the initial four multi-purpose services involved in the pilot program would have been suitable for study. The present study was planned during 2005, when twenty-two multi-purpose services were identified in the New South Wales Department of Health Annual Report (2005). This number was sufficient to expect a larger pool of
potential participants who had been through the experience of amalgamating health services into multi-purpose services.

1.3 Research Aims

The aim of this constructivist grounded theory study was to reveal the main concerns of participants involved in a social environment of creating new multi-purpose services in rural New South Wales and to understand how participants dealt with those concerns. This understanding of participant experiences would then be used to construct a substantive grounded theory. Participants included community members, managers and staff members to obtain a complete picture of that experience. Constructivist grounded theories consist of an interpretation of conceptualised phenomena in abstract terms and are useful in understanding the multiple realities of participants (Charmaz, 2006).

For the purposes of the present study a multi-purpose service was a health service which had been recognised as a multi-purpose service through an agreement involving the Commonwealth and State Governments and the local area health service. These multi-purpose services were drawn from the Greater Western Area Health Service. At the time when the multi-purpose services were being developed, the Greater Western Area Health Service did not exist, so comments from participants about the area health service could refer to any of the three area health services which were combined to create the Greater Western Area Health Service (Far West Area Health Service, Macquarie Area Health Service and Mid Western Area Health Service).
1.4 Significance of this Research

The present study is significant due to the lack of research which has been undertaken into the development of multi-purpose services. Combining Commonwealth and State health responsibilities in a single health service is a relatively new phenomenon which has not yet been studied in depth. Despite a lack of research in the area of multi-purpose service development, further developments are planned. In 1992, a National Health Strategy background paper (Reid & Solomon, 1992) suggested that 152 rural health services in New South Wales and Queensland were suitable for development as multi-purpose services. In 2008, although several sites were under development, only 69 multi-purpose services were in existence in those States. These recommendations indicate that further development of multi-purpose services are likely to go ahead (Ageing and Aged Care Division, 2008). This is supported by New South Wales Health in their State Health Plan, Towards 2010 (NSW Department of Health, 2007) and a recently released report by the National Health and Hospitals Reform Commission (2009). Many people involved in these proposed sites should find research based on the experiences of others who have been involved in the development to be significant and the findings to provide guidance in how to develop their sites more effectively.

The voices of different participants, particularly those in a rural context, have also not been sufficiently explored in merger situations. The present study will add to the current literature related to health service mergers by presenting an understanding of the experiences of people employed by the health service and community members. As multi-purpose services are located in rural areas which have a strong sense of
community cohesion, a major change in the health service delivery warrants an investigation of their concerns.

1.5 Methodology

Little research has been undertaken in the area of multi-purpose service development, making this a suitable area for a grounded theory study. Grounded theory is appropriate for the investigation of social experiences which focus on understanding rather than measurement. Grounded theory methodology allows for the construction of a theory describing the social process without the imposition of a predetermined theory. It enables the individual perspective of each research participant who has been involved in the development of a multi-purpose service to be heard. Acknowledging each of these perspectives was possible with a constructivist perspective.

1.6 Overview of the Thesis

This thesis consists of a total of nine chapters. The purpose of this first chapter has been to situate the present study within the Australian rural health context which led to the creation of a new model of health service delivery – the multi-purpose service. The multi-purpose service model was described and financial issues leading to its creation were discussed. Multi-purpose centres were also described to ensure clarity was provided when discussing two such similar entities. A lack of research in this area has been identified, and the aim and significance for the present study have been presented. An introductory overview of the research methodology being used was also presented.
Chapter One: Introduction

Chapter Two situates the study within the broader literature of mergers and the impact of mergers on organisational culture. This general literature is followed by a specific review of multi-purpose services and their objectives to position the present study within what is already known about multi-purpose services. This chapter highlights the gap in the literature related to the development of multi-purpose services, describing a need for further research in this area.

Chapter Three outlines the benefits of using a constructivist paradigm for the present study and its relationship with grounded theory methodology and symbolic interactionism. A brief history of grounded theory is provided to clarify the differences between grounded theory methodologies. The features of grounded theory are also described from a constructivist perspective in order to clarify the perspectives which guided the present study.

In Chapter Four the research aims are presented and linked to the application of the grounded theory method used in the present study. In keeping with grounded theory data generation and analysis took place concurrently but, for clarity, each are discussed separately, and examples from the data are presented to demonstrate how grounded theory was applied in the present study.

Chapter Five describes the core category which emerged from the analysis of the data as being a central concern for all participants. This core category of *Anticipation of Risk* was conceptualised as having two properties: judging motive and controlling risk and dimensions of *trust* and *suspicion*. Each of these features is discussed and illustrations
from the data are provided. *Anticipation of Risk* weaves through each phase of the basic social process described in Chapter Six.

Chapter Six elaborates on the data which led to the development of the three-phased basic social process. It provides detail of each of the three phases of *driving change*, *engaging with stakeholders* and *collaborating*. Each of these phases has several properties which are also described in this chapter.

The seventh chapter presents the substantive grounded theory which was constructed in the present study. The theory is presented as a set of theoretical constructs which form a three-phased process of ‘Developing a Collaborative Rural Health Service Identity’. Together the theoretical constructs presented in this chapter describe the experiences of participants who were involved in the development of multi-purpose services.

Chapter Eight discusses the substantive grounded theory of ‘Developing a Collaborative Rural Health Service Identity’ in the context of relevant literature. It compares and contrasts the findings from the present study to those found in the current literature.

The final chapter, Chapter Nine, describes the limitations of the study, its implications and recommendations for future multi-purpose service developments. Specific recommendations for health policy, education, practice and future research are identified.
1.7 Summary

The multi-purpose service model of health service delivery was developed to address the unique needs of the rural Australian population (Sach & Associates, 2000; Hoodless & Evans, 2001; National Rural Health Alliance & Aged and Community Services Australia, 2004). The multi-purpose service model is flexible so as to meet the individual needs of each community and allows the pooling of funding from both Commonwealth and State Governments. In order to address the difficulties inherent in rural health care, multi-purpose services have continued to be developed combining existing hospitals and aged care services in rural Australia (Neumayer, Chapman, & Whiteford, 2003; Department of Health and Ageing, 2008). There is insufficient research into the development of multi-purpose services, particularly related to the experiences of participants who have been involved in the development of these new services. This chapter has introduced the multi-purpose service model and its features and provides an overview of the current study.

As multi-purpose services are formed by integrating acute health care and aged care services, their development frequently involves the merger of at least two of these services. In the following chapter literature related to organisational mergers and organisational culture and change will be reviewed as well as the literature specifically related to multi-purpose services.
CHAPTER 2. LITERATURE REVIEW

A multi-purpose service is an integrated health and aged care service (Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). Such integration requires the merger of at least two services: a Commonwealth-funded aged care service and a State-funded acute care service. This thesis aims to develop a better understanding of the development of multi-purpose services from the perspectives of the people involved.

Little literature is available about multi-purpose services and there is much less about their development. For this reason more general literature related to mergers and cultural integration is considered. In keeping with grounded theory only a general literature review was undertaken before data collection, with a more detailed review carried out after a theory had emerged from the data. The timing and depth of literature reviews in grounded theory studies are explained in more detail in Chapter Three (see Literature Review in Section 3.2.4).

The current chapter discusses the literature available about mergers generally, with a review of expected benefits and possible issues. Mergers which are deemed to be successful frequently focus on the management of organisational culture and cultural change (Lodorfos & Boateng, 2006; Nambudiri, 2006; Nikandrou & Papalexandris, 2007; Stinchcomb & Ordaz, 2007; McGreevy, 2009) so these are also discussed. This chapter then concludes with a discussion of literature about multi-purpose services in particular. The objectives of multi-purpose services are clearly articulated in the
provide a framework for discussing the success and issues which have been identified in multi-purpose services to date.

2.1 Organisational Culture

A culture can be defined as a group of individuals who share common understandings, attitudes, values, beliefs and actions which are communicated from one generation to the next (Minami, 2002; Nambudiri, 2006; Edgar & Geare, 2009; Singh, 2009); this definition has also been applied in research into health care organisations (Davies, Nutley, & Mannion, 2000; Chaboyer, Najman, & Dunn, 2001). These commonalities are the basis of each individual’s world view, which informs individual attitudes and behaviours (Brown et al., 2005). Organisations develop in the interest of taking common purposeful action, but they are social systems, which are constantly changing to meet both internal and external demands. The common purpose of the organisation links activities and provides employees with legitimacy for their actions. These behaviours and underlying values are constantly being redefined as a result of organisational experience to develop a common culture among employees (Checkland & Scholes, 1990; Checkland & Holwell, 1998; Nambudiri, 2006; Singh, 2009).

Organisational culture is often described as having three levels (artefacts, values and assumptions). Artefacts are the easiest level of a culture to change (Davies et al., 2000; Schein, 2004; Nambudiri, 2006; Jung et al., 2007; Singh, 2009). Clusters of artefacts are described as physical symbols (architecture, dress codes, office layout), language (jargon, metaphors, logos, nicknames), traditions (rituals, routines) and stories (legends,
Artefacts provide an insight into the underlying values of the culture.

Shared values consist of the rule systems that guide a common culture. Values can be consciously perceived and articulated and provide a sense of security to members of the culture (Jones & Redman, 2000; Nambudiri, 2006; Jung et al., 2007). Although several frameworks of organisational values exist, they have many similarities (Cameron & Quinn, 1999; Jones & Redman, 2000; Hofstede & Bond, 2001; Pettinger, 2002; Fulop et al., 2005). The widely used (Helfrich, Li, Mohr, Meterko, & Sales, 2007; Jung et al., 2007; Skela Savič et al., 2007; Skela Savič & Pagon, 2008b, 2008a) competing values framework initially described by Cameron and Quinn (1999) links these features as two dimensions to demonstrate their impact on each other. One differentiates those criteria which emphasise flexibility, discretion and dynamism from those which reflect stability, order and control. The other dimension differentiates those criteria which emphasise internal orientation, integration and unity from those that indicate external orientation, differentiation and rivalry. In combination these two dimensions form four cultural values (Figure 1) which are a group or clan culture; a developmental or ‘adhocracy’ culture; a hierarchical culture; and a rational or market culture (Cameron & Quinn, 1999; Hofstede & Bond, 2001; Pettinger, 2002; Moynihan & Pandey, 2003; Fulop et al., 2005). Organisations are unlikely to be characterised by just one of these values but rather have a combination with some emphasised more strongly than others (Giberson, 2001).
A group or clan culture has a focus on the individuals within it; teamwork, participation and morale are considered important. The workplace is friendly and values loyalty and tradition. Managers concentrate on long-term human resource management and desire consensus. Levels of management are often low, with employees trusted to adhere to common values. Leaders often undertake a mentoring role and empower team members (Cameron & Quinn, 1999; Jones & Redman, 2000; Moynihan & Pandey, 2003).

A developmental culture or ‘adhocracy’ is focused on innovation and creation, encouraging change and risk taking. Leaders are innovators with power, often moving from one team to another as different problems are addressed. There is an emphasis in this organisation on leading the way, meeting new challenges and looking toward the future adapting quickly to changing environments (Cameron & Quinn, 1999; Jones & Redman, 2000; Moynihan & Pandey, 2003).
A hierarchy is a highly formalised culture with strict rules and procedures to govern the work of individuals and ensure stability. Leaders organise and coordinate staff to ensure consistency and efficiency (Jones & Redman, 2000; Moynihan & Pandey, 2003). Decision making authority and accountability are clear. A hierarchy is an effective organisation when environmental conditions are stable and is often used in large organisations including government departments (Cameron & Quinn, 1999). Modern hierarchies have fewer levels in their structures than previously and are still a logical and effective way to organise those workplaces where multiple, complex tasks are undertaken by large groups of employees. From the perspective of employees a hierarchy also allows greater potential for promotion than cultures governed by other organisational values (Moynihan & Pandey, 2007).

An organisation with rational or market values has an external focus and is goal oriented with an emphasis on competition; its success is measured by market share, production and efficiency. Leaders are hard competitors who are demanding of their staff (Jones & Redman, 2000; Moynihan & Pandey, 2003). These organisations often take an aggressive stance, are hostile towards competitors and constantly attempt to improve their position in their industry (Cameron & Quinn, 1999).

Underlying organisational values are cultural assumptions. These are taken for granted; they are non-debatable views of the world which are strongly influenced by the environment that individual members of a culture live in. Challenges to assumptions are often immediately dismissed (Davies et al., 2000; Schein, 2004; Nambudiri, 2006; Jung et al., 2007). These three cultural levels (artefacts, values and assumptions) need to be
taken into account when implementing cultural change. Merely changing the most obvious features, the artefacts, will not necessarily produce a change in underlying values or assumptions.

### 2.1.1 Positive Organisational Cultures

In health, positive organisational cultures are associated with a variety of benefits, including improved employee satisfaction, communication, patient outcomes and patient safety. When health workers are described as having a positive perception of the organisational culture, they often express greater satisfaction with their employment (Moynihan & Pandey, 2003; Stone et al., 2005; Warren et al., 2007). Likewise those organisations which are seen as having a positive organisational culture describe improved communication among health workers, particularly when they have low hierarchical structures and focus on shared governance (Meterko, Mohr, & Young, 2004; Kuokkanen et al., 2007).

Teamwork is frequently described as an aspect of a positive organisational culture which can enhance quality improvement programs and thereby patient outcomes in a variety of areas, for example, cardiac intervention times (Bradley et al., 2006; McCarthy & Blumenthal, 2006; Vina, Rhew, Weingarten, Weingarten, & Chang, 2009) and reduction of falls (Kalisch, Curley, & Stefanov, 2007). Some studies which researched benefits of teamwork also indicated that staff turnover was reduced (Aarons & Sawitzky, 2006; McCarthy & Blumenthal, 2006; Kalisch et al., 2007; Mohr, Burgess, & Young, 2008).
Similarly, a patient safety subculture has been identified as an aspect of a positive organisational climate which relates specifically to health and safety within the organisation. Such a focus on managing risk, commitment to patient safety and communication has been linked to an improvement in patient safety (Stone et al., 2005; Feng, Bobay, & Weiss, 2008; Singer et al., 2009). Together these benefits indicate why organisations aim to create positive cultures and to avoid negative organisational cultures.

2.1.2 Limitations of Organisational Culture

Cultures impose constraints on individuals to conform to normative behavioural patterns. Individuals interact with these behavioural patterns which are contested to determine how the culture will change (Blackford, 2003). This ability of individuals to influence culture gives individuals the ability to refuse to conform (Wuthnow, 1984) which allows them to impact on the group culture. Sometimes the behaviour which is learnt from cultural norms can have negative results, such as bullying in the workplace (Curtis, Ball, & Kirkham, 2006; Hutchinson, Vickers, Jackson, & Wilkes, 2006a, 2006b; Lewis, 2006; Randle, 2006).

The assumption that a cohesive or monolithic culture of employees exists in each workplace is viewed by some authors (Jaynes, 1997; Checkland & Holwell, 1998; Davies et al., 2000; Risberg, 2003; Jung et al., 2007) as being overly simplistic, although it has the benefit of being more easily described and studied. This simplistic understanding ignores multiple interpretations of individuals within an organisation, producing a reality where subcultures of the organisation are not usually considered,
rather, an ‘average’ is studied (Jaynes, 1997; Checkland & Holwell, 1998; Risberg, 2003; Barabel & Meier, 2006). When subcultures develop, they are habitually viewed as a managerial failure to control the workforce – the workforce which managers are expected to control through the creation of shared values and norms (Risberg, 2000; Kavanagh & Ashkanasy, 2006).

However, health professionals consist of occupational groups which function as communities; their members are bound by a common sense of identity, values, role definitions and language: their own culture (Chaboyer et al., 2001; Gibb, Forsyth & Anderson, 2005; Rowe & Boyce, 2009). Health professionals have considerable power and autonomy and frequently resist the attempts to change their behaviour (Lewis, 2004; Fulop et al., 2005). The different cultures of health professionals can also limit the degree of interdisciplinary collaboration in the workplace (Orchard, Curran, & Kabene, 2005; Pollard, Ross, & Means, 2005; Skela Savić et al., 2007; Malloy et al., 2009; Meads, Jones, Harrison, Forman, & Turner, 2009). When organisational change is implemented, each subculture may have differing perceptions about what is and should be happening, which can impact on the success of the change effort.

2.1.3 Relevance for Multi-purpose Service Development

Each of the previously existing organisations which will merge into a multi-purpose service can be expected to have some unique cultural values that have allowed them to function successfully in the past. The differences in these values and underlying assumptions may create issues in an amalgamated organisation. Managers, who desire the benefits of a positive organisational culture, need to be aware that changing the most
obvious features of that culture (the artefacts) are unlikely to impact greatly on the underlying values or assumptions that pre-existing employees hold. Mergers are a dramatic form of organisational change which has a significant impact on organisational culture.

2.2 Organisational Mergers

An organisational merger involves the amalgamation of two or more previously independent organisations (Terry & O’Brien, 2001; Väänänen, Pahkin, Kalimo, & Buunk, 2004). As literature related to health mergers and in particular to multi-purpose services is limited, an examination of the issues related to general organisational mergers provides an insight into what may occur in multi-purpose services.

Mergers occur relatively frequently in health care systems, particularly in Britain (Bojke, Gravelle, & Wilkin, 2001; Cereste, Doherty, & Travers, 2003; Fulop et al., 2005; Drummond-Hay & Bamford, 2009) and the United States of America (Kitchener & Gask, 2003). Rural Australia has begun to follow this lead with the development of multi-purpose services which aim to integrate multiple health services, by merging existing services. These mergers are undertaken in the hope of attaining benefits commonly related to strategic fit, economies of scale and improved coordination of services.

2.2.1 Benefits of Mergers

A wide range of incentives exist for mergers in industry, including undervaluation of the target organisation’s stock, perception of superior competence and market power
considerations, to ensure future survival and synergistic benefits. In public health care organisations, synergistic benefits are of major significance. These synergies include strategic fit, improved coordination of services and economies of scale (Layne, 2000; Zimmerman & Dooley, 2001; Huck & Konrad, 2004; Nambudiri, 2006).

**Strategic Fit**

The general literature relating to organisational mergers describes the need for managers to consider the ability of the merging organisations to ‘fit’ together. Two interpretations of strategic fit are described in the literature. One involves similarity, indicating that homogeneity allows merging organisations to work well together, with similar backgrounds and work processes leading to improved communication, cooperation and understanding between the two merged entities (Krishnan, Miller, & Judge, 1997; Larsson & Finkelstein, 2002; Risberg, 2003; McDonald, Coulthard, & de Lange, 2005). On an organisational and cultural level, this type of ‘fit’ or similarity assists in avoiding conflict, but similar organisations do not necessarily cooperate or reach consensus (Risberg, 2003).

The other interpretation of strategic fit (complementarity) focuses on dissimilarities; how an organisation’s weaknesses could be improved through the strengths of another; how one service could be expanded with that of another organisation. This complementarity recognises the skills and abilities of each organisation, giving each importance and value that the other does not have. It is viewed as being more valuable than similarity, as it enhances the value of the resultant organisation, rather than merely enabling integration (Krishnan et al., 1997; Harrison, Hitt, Hoskisson, & Ireland, 2001).
When merging organisations are selected for complementarity, their range of services can improve as can their flexibility to meet market and community needs. Complementary management backgrounds have a positive impact on post-acquisition performance outcomes for organisations and reduced turnover of management team members. Complementary backgrounds reduce the duplication of services and staff (including management), thus reducing the amount of conflict reported (Krishnan et al., 1997). Complementarity frequently aims to improve the coordination of services.

**Improved Coordination of Services**

Some mergers aim to improve their services by coordinating them under one organisational structure (Robinson, 1996; Bojke et al., 2001). Mergers can provide positive results when failures of coordination, such as misaligned incentives, duplication of services, excess capacity and inadequate scale, exist (Robinson, 1996). However, there is frequently an initial downturn in productivity due to poor staff morale and the costs associated with rationalisation of facilities (Cereste et al., 2003). In the longer term, higher volumes of activity in specialised units can increase effectiveness, provide a larger staff and expertise base, improve training and education, and improve recruitment and retention rates (Cereste et al., 2003; Fulop et al., 2005). Improving coordination between services may have financial benefits in the merged organisation.

**Economies of Scale**

The size of services is often a driving factor for mergers, with a pooling of resources leading to better bargaining power and securing the financial viability of smaller
organisations. However, optimal size differs in relation to organisational factors such as the aims, functions and tasks of the organisation, which can be dictated by environmental factors including demographic, socioeconomic and area characteristics (Robinson, 1996; Bojke et al., 2001; Cereste et al., 2003; Fulop et al., 2005).

When budgets are allocated on a per capita basis, the formation of a merger frequently creates the expectation of a reduction in management and administrative costs. In order to obtain economies of scale, mergers frequently result in the consolidation of departments and integration of functions, leading to redundancy of employees (Layne, 2000; Bojke et al., 2001; Cereste et al., 2003; Krishnan, Hitt, & Park, 2007; Tang & Timmer, 2008). Managers may perceive these as advantages of economies of scale but employees may perceive them to be disadvantages as they can be associated with a loss of jobs (Vaara, 2002). Some authors (Carleton & Lineberry, 2004; Ullrich, Wieseke, & van Dick, 2005; van Dick, Ullrich, & Tissington, 2006; Kjekshus & Hagen, 2007; McGreevy, 2009) warn that mergers have a low success rate, particularly those which are focused on financial issues rather than cultural integration.

2.2.2 Limitations of Mergers

The issues commonly identified in unsuccessful mergers include time frames and difficulties changing organisational culture. Organisational restructuring in mergers usually focuses on ‘rapid radical change’ (Walston, Lazes, & Sullivan, 2004). However, several authors (Cereste et al., 2003; Gardiner, 2003; Walston et al., 2004; Ullrich et al., 2005) have found that implementation time frames are too short, particularly in public enterprises where governance by consensus is often desired. In a comparison of three
merger time frames, Kavanagh and Ashkanasy (2006) found that an incremental approach led to more satisfactory outcomes for individuals who were less resistant to change and regarded leaders in a more positive light.

Mergers frequently create additional work in short time frames for managers who over time implement change, but are often unsuccessful in doing so. This additional work leads to situations where changes are often hurried, sometimes shallow, and not appropriately executed (Walston et al., 2004). When change is shallow, the pre-existing organisational identity is frequently maintained for lengthy periods of time rather than being changed to suit the new organisation (Gardiner, 2003; Fulop et al., 2005; Ullrich et al., 2005). Several authors (Lodorfos & Boateng, 2006; Nambudiri, 2006; van Dick et al., 2006; Stinchcomb & Ordaz, 2007; McGreevy, 2009) indicate a need to focus on organisational culture in order to merge two organisations effectively.

2.3 Impact of Mergers on Organisational Culture

A number of authors suggest that there are four possible outcomes of cultural mergers – coexistence, integration, absorption and deculturation (Demirov, 2002; Risberg, 2003; Rudmin, Dinnel, Hayes, & Sattler, 2003; Nambudiri, 2006) – which have also been applied to health care organisations (Disch & Taranto, 2002). Coexistence involves a merger where neither original organisation loses its identity or association with its original groups. In situations of coexistence each culture believes it is superior to that of the other and both attempt to maintain their independence. Coexistence minimises the cultural exchange between the two cultures. It can refer to self-imposed withdrawal
from the organisation or resistance to the power being exercised by the other culture (Demirov, 2002; Rudmin et al., 2003; Nambudiri, 2006).

Integration involves a merger where a third culture is created as the two organisations combine. Integration is often recommended as the best outcome, but it is the most difficult to achieve, with coexistence often being a first step in a lengthy progression, where the effort required is often underestimated (Disch & Taranto, 2002; Mitleton-Kelly, 2004). In situations of integration, the resultant culture takes on characteristics from both of the pre-merger cultures to form a unique identity of its own. No one culture dominates the other, instead, a balanced and mutual learning and adaptation take place (Demirov, 2002; Mitleton-Kelly, 2004; Nambudiri, 2006). Although a merger of two equal partners can exist, in reality, it is inevitable that one or the other will be more influential in shaping the resultant organisation (Ullrich et al., 2005; Kavanagh & Ashkanasy, 2006).

Absorption or assimilation involves a merger where one culture overtakes and eliminates the other. In situations of absorption the dominant organisation’s culture is seen to be more attractive than that of the other organisation. Sometimes absorption involves the dominant organisation imposing its own culture and procedures. Frequently members from the dominant culture are placed in key positions. It involves a one-sided proceeding where the non-dominant culture will eventually be absorbed and cease to exist (Demirov, 2002; Risberg, 2003; Rudmin et al., 2003; Mitleton-Kelly, 2004; Nambudiri, 2006). Absorption involves the greatest change, especially for the non-dominant culture, which frequently loses its identity and large numbers of its workforce,
including its management (Krishnan et al., 1997). For employees of the dominant organisation, the merger may increase their identification with the organisation which they then perceive as being more successful than it had been previously (Ullrich et al., 2005; Bartels, Douwes, de Jong, & Pruyn, 2006; Kavanagh & Ashkanasy, 2006).

Deculturation is the rejection of both cultures. In situations of deculturation, both organisations view their culture as unattractive; this results in confusion and sometimes leads the new organisation to disintegrate (Demirov, 2002; Nambudiri, 2006). Deculturation is rarely accepted by organisational members who usually create a new culture, so is poorly described in the literature (Rudmin et al., 2003).

2.3.1 Role of Managers

The literature, as explained earlier, identifies that greater benefits accrue to organisations that have a positive organisational culture than to ones that do not, and it is the managers who tend to be given the job of creating a positive culture when mergers occur. Cultural control is portrayed as cheap, avoiding resentment and building the commitment of employees to the organisation, despite cultures being depicted as being dynamic, active and resistant to change (Beil-Hildebrand, 2002; Greenhill, 2006). Several authors (Beil-Hildebrand, 2002; Kavanagh & Ashkanasy, 2006; McDonald, Coulthard, & de Lange, 2007; Marshall, 2009; McGreevy, 2009) provide advice on how to manage organisational cultures as the success or failure of a merger is sometimes seen to depend mainly on the ability of the managers involved in the change (Gomes, Donnelly, Morris, & Collis, 2007).
In newly merged organisations, there was frequent competition between managers from the previous organisations to win management positions, with senior positions tending to be dominated by one pre-existing organisation (Gardiner, 2003; Fulop et al., 2005). Staff from the non-dominant organisation expressed feelings of being ‘taken over’ (Fulop et al., 2005). Delays in appointing managers left some services lacking representatives with sufficient authority to take action and participate in discussions (Cereste et al., 2003; Fulop et al., 2005). New managers were appointed to units with which they were unfamiliar, and instructed to implement major changes. They lacked knowledge of the operation of those departments and lacked the confidence of the staff that worked in them, which inhibited their ability to implement change (Walston et al., 2004). When managers continued in their original positions, responsibility for implementing the merger was often added to their other responsibilities. They were expected to continue their normal work simultaneously with these new responsibilities, often without assistance (Risberg, 2003; Walston et al., 2004). These additional responsibilities resulted in a reduced focus on service provision (Cereste et al., 2003; Fulop et al., 2005; Yu, Engleman, & van de Ven, 2005).

Several authors (Walston et al., 2004; Swanepoel, 2005) recommend the use of consultants to relieve some of the burdens caused by a merger, particularly in those circumstances where managers lack the skills required. Usually consultants were employed in the planning phase, but Walston et al. (2004) found that those health services which hired facilitators for the duration of the merger had a smoother implementation.
However, Bryson (2003) attributes a large part of merger success to the ability to make local decisions, rather than having decisions imposed from distant management (or consultants) which can be described as demoralising and disruptive. Frequently consultants were engaged for their financial skills, but they knew little about engaging employees or creating change. When staff members were not involved in the process or were suspicious about the data being used, credibility for the merger was lacking among employees (Walston et al., 2004).

Despite the prevalence of mergers, evidence suggests they are often disappointing with positive results taking a long time to be achieved (Jones & Redman, 2000; Bojke et al., 2001; Bryson, 2003; Bartels et al., 2006; Gordon, 2008). Mergers could not realise their full potential without positive input from staff members. Managers were often tasked with the role of finding a balance between the interests of the organisation and those of the staff (Bryson, 2003).

2.3.2 Staff Members

The assets of service industries, such as health care, are not factories and equipment, but people, who have a tendency to leave if work becomes uncomfortable. Systems involving people are complex; their behaviour is not always predictable and they are able to self-organise and influence each other. Although this complexity inhibits the ability of managers to manipulate the organisational culture, this ability to co-evolve can lead to creative and innovative results (Piderit, 2000; Mitleton-Kelly, 2004; Greenhill, 2006). Organisational change literature with its focus on managers and their role in managing change predicts the need to overcome resistance to change. A focus on
Chapter Two: Literature Review

overcoming resistance portrays subordinates or staff members as obstacles to change. Organisational change literature frequently recommends open and early communication as a method to overcome resistance among staff members (Kummer, 2008; McLaren, Woods, Boudioni, Lemma, & Tavabie, 2008; Greasley, Watson, & Patel, 2009; Marshall, 2009; McGreevy, 2009). Other strategies for managing staff members in organisational change situations are related to workforce stability and organisational identity.

A key risk management strategy for change management (particularly mergers) includes maintaining the stability and morale of the workforce (Grantham, 2007; Hodge, 2008; Kummer, 2008; Marshall & Olphert, 2008; Marshall, 2009). Some authors (Bryson, 2003; Sharpe, 2006; Hodge, 2008; Madondo, 2008; Reissner, 2008) indicate that features which impact on workforce stability and are threatened in organisational change include job security, procedural fairness and communication. The stressful nature of workforce instability can also impact on the health of staff members and retention of staff during organisational change (Fulop et al., 2005; Greenhill, 2006; Kavanagh & Ashkanasy, 2006; Grantham, 2007; Skela Savić & Pagon, 2008a). Some managers may get so caught up with their own survival that they may not offer enough time and attention to their employees during this stressful period. This has a negative impact on morale and leaves employees feeling less committed to the organisation (Risberg, 2003; Walston et al., 2004).

Kavanagh and Ashkanasy (2006) suggest that frequently it is the role of managers to assist staff to accept the new organisational identity. Staff members identify with
organisations when the values underlying the organisational culture are congruent with their own. Employees derive a portion of their self-esteem from the organisation and are thereby motivated to work towards its goals to derive job satisfaction, which improves staff retention (O’Reilly, Chatman, & Caldwell, 1991; Ullrich et al., 2005; Bartels et al., 2006; van Dick et al., 2006; Tang & Timmer, 2008). Neglecting organisational identity can contribute to the failure of organisational change efforts (Balmer & Dinnie, 1999; Gustafsson & Hukkanen, 2002; Gardiner, 2003; Bartels et al., 2006; McDonald et al., 2007). Although mergers incorporate an employee’s original organisation, it is not unusual for the employee to feel that the new organisation is no longer their own and their identity is under threat. Members of acquired organisations feel they have lost their identity and members of the acquiring organisation fear that their organisation’s positive reputation may be diluted or ruined by the merger (Risberg, 2003; Millward & Kyriakidou, 2004; Ullrich et al., 2005; van Dick et al., 2006). Some authors (Millward & Kyriakidou, 2004; van Dick et al., 2006) recommend encouraging employees to give up their old organisational identity by making it appear unattractive in comparison to the new merged identity, which should appear prestigious and distinctive. The need for a shared identity associated with radical and complete change will actually increase the feeling of discontinuity for employees (Ullrich et al., 2005).

2.3.3 Relevance for Multi-purpose Service Development

The benefits which can be gained from organisational mergers are closely related to the objectives of multi-purpose services. Considering the strategic fit of previous organisations before a merger is attempted may assist in developing multi-purpose
services which meet community needs and improve coordination of services. The objectives of multi-purpose services identify integration as the most desirable merger outcome, but literature related to the development of such an outcome in multi-purpose services was not found.

As mergers of pre-existing services are expected in the development of multi-purpose services, it would be necessary (and obvious) for studies or reports to evaluate the success of the new organisation. Several authors (Sach & Associates, 2000; Evans et al., 2006) suggest that positive benefits from the new organisation cannot be expected until two to three years after the merger has commenced. Some delays in achieving positive results in new multi-purpose services include multiple expectations and delays in facility re-development (Sach & Associates, 2000). Similarly in 130 interviews of 99 British health service mergers, Fulop et al. (2005) reported that the feeling of being ‘taken over’ is inevitable and lasts for up to three years. In other non-health related merger research, two to five years is also suggested as the minimum time taken by organisations to adjust to the new situation (Gustafsson & Hukkanen, 2002).

2.4 Multi-purpose Services

In the previous sections organisational cultures, change management and mergers have been explored. In each of these sections the importance and relevance for multi-purpose services have been examined. In this section the limited literature about multi-purpose services is reviewed, the majority being descriptive information produced by various government departments (Multipurpose Services Taskforce, 1991; Mott, Snowball, Vernon, & Williams, 1995; Department of Human Services (Vic), 1996a, 1996b;
Australian Health Ministers’ Advisory Council’s National Rural Health Policy Subcommittee, 2002). There have been four evaluations of multi-purpose services (Andrews et al., 1995; Sach & Associates, 2000; Neumayer et al., 2003; Nicoll et al., 2004) and two literature reviews (Bidwell, 2001; Wakerman et al., 2006). Several recommendations to expand or continue the program have been made (Reid & Solomon, 1992; NSW Department of Health, 2007; Garling, 2008). However, the limited literature which addresses the implementation of the multi-purpose service model focuses on a single case study (Hoodless & Evans, 2001; Evans et al., 2006). A fundamental gap in the literature about multi-purpose services is a lack of the individual voices of the people who have had experience with the development of multi-purpose services. Due to the limited sources available some grey literature has also been included in this literature review, in particular, relevant conference papers. Literature relevant to multi-purpose services is summarised in Table 1 below where a total of eighteen items are identified.
Table 1: Literature related to Multi-purpose Services

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Type of Literature</th>
<th>Results (related to MPS objectives)</th>
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<tbody>
<tr>
<td>Multipurpose Services Taskforce, 1991</td>
<td>Multipurpose Services Taskforce Final Report</td>
<td>Report</td>
<td>Proposed the development of MPS</td>
</tr>
<tr>
<td>Mott, Snowball, Vernon &amp; Williams, 1995</td>
<td>Multipurpose and Integrated Health Services: Development Guide</td>
<td>Development Guide &amp; example of 1 successful WA MPS</td>
<td></td>
</tr>
</tbody>
</table>
• Improved cost effectiveness, may be significantly delayed  
• Improved coordination of services  
• Community endorsement of the model |
| Mensink, 1995 | MPS – Rural bonus. Australian Nursing Journal | Case study of 1 WA MPS | • Improved flexibility of staff  
• Improved coordination of services  
• Increased number of services |
<p>| Humphreys, Mathews-Cowey &amp; Rolley, 1996 | Health service frameworks for small rural and remote communities: Issues and options | Descriptive &amp; example of 2 successful MPS (NSW &amp; WA) | |
| Department of Human Services (Vic), 1996a, 1996b | The MPS Option: Health &amp; Aged Care in Rural Communities Multi Purpose Services: Development and Design Guidelines, Health and Aged Care in Rural Communities | Descriptive Guide &amp; example of 3 successful Vic MPS | |
| NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000 | Report to the NSW Minister for Health: A Framework for Change | Report | • 108 recommendations, including identification of 20 sites to be developed as MPS |</p>
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<td>• Improved flexibility of services&lt;br&gt;• Improved cost effectiveness, may be significantly delayed&lt;br&gt;• Improved coordination of services, especially with a devolved organisational structure</td>
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<td>Successful Models of Rural Health Service Delivery and Community Involvement in Rural Health: International Literature Review</td>
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<td>Hoodless &amp; Evans, 2001</td>
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<td>Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002</td>
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<td><em>A Systematic Review of Primary Health Care Delivery Models in Rural and Remote Australia 1993–2006</em></td>
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Large variations in population lead to major differences in needs and ability to sustain health services in rural and remote Australia (Sach & Associates, 2000; Hoodless & Evans, 2001; National Rural Health Alliance & Aged and Community Services Australia, 2004). The multi-purpose service model is an integrated health service consisting of acute care and aged care. At the time when the multi-purpose service model was introduced as an innovative health service model, many of the small rural hospitals which were suitable for development as multi-purpose services were already providing a range of services, but the legislation involved enabled them to pool funds (Reid & Solomon, 1992; Department of Human Services (Vic), 1996a; Hartley, 2003).

In 1992, the Commonwealth Government provided funds to develop a Pilot Multi-purpose Services Program involving 11 sites: South Australia (2), Western Australia (2), New South Wales (4), Queensland (1) and Victoria (2). The multi-purpose service model was seen as a solution to health problems being experienced in rural Australia (Andrews et al., 1995). These problems included a) inferior health to their metropolitan counterparts (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Australian Institute of Health and Welfare, 2005; Greater Western Area Health Service, 2007; Independent Pricing and Regulatory Tribunal, 2008; Wakeman & Humphreys, 2008); b) difficulty attracting staff (Fraser et al., 2002; Humphreys, Jones et al., 2002; Healy et al., 2006; Garling, 2008; Independent Pricing and Regulatory Tribunal, 2008); and c) a lack of viability and range of health services in rural areas (National Rural Health Alliance & Aged and Community Services Australia, 2004).
Currently in Australia, there are 117 multi-purpose services in operation (47 are in New South Wales) with more under development. Funding for new developments is provided through the Multi-purpose Service Program (Department of Health and Ageing, 2008). Multi-purpose services are legislated as flexible care services under the Commonwealth Aged Care Act 1997 (Section 49) which requires them to provide an integrated service consisting of:

(a) residential care; and

(b) at least one of the following:
   (i) a health service provided by a State;
   (ii) a home and community care service;
   (iii) dental or other health care;
   (iv) transport services;
   (v) community care under the Act;
   (vi) a service for which a medicare benefit is payable under the Health Insurance Act 1973;
   (vii) the provision of a pharmaceutical benefit under the National Health Act 1953;
   (viii) a service that the Minister nominates, in an agreement with the responsible Minister of the State, as an appropriate service (Commonwealth of Australia, 2005).

The model of health service delivery in multi-purpose services has a strong focus on meeting community needs. This focus acknowledges the unique nature of the
communities involved and their different needs, leading to services being combined in a unique mix for each community. Despite some multi-purpose services featuring a large range of these services, it is also possible for an existing hospital to convert some of its acute care beds into residential aged care beds to meet these requirements, without other services being involved.

The majority of multi-purpose services aim to function on one site as a ‘one stop shop’ for health care within that particular community. However, being on one site is not essential, with several multi-purpose services operating over multiple sites (Sach & Associates, 2000; Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). The flexibility in meeting individual community needs provides little guidance to managers or community members about what they can expect.

Despite an ‘enormous demand’ to develop multi-purpose services (Snowball, 1994, p. 40), they are not considered to be suitable for all communities. In a later evaluation of five Victorian multi-purpose services, Sach and Associates (2000) found that conditions consistent with a successful multi-purpose service development included a population which was too small to sustain separate services (1000–4000 people); isolation from mainstream services; similar service boundaries for core existing services; a single set of services; and existing service providers and a community that were supportive of the multi-purpose service concept. The first two of these conditions were also identified by the earlier national evaluation of the Pilot Multi-purpose Services Program (involving eleven sites) by Andrews et al. (1995).
Developing a multi-purpose service requires the approval of both Commonwealth and State Health Ministers. State and Commonwealth support are provided to assist in community consultation and an assessment of health and aged care needs. A plan of how services could be better delivered to meet health and aged care needs within the community is agreed upon by all relevant service providers. Appropriate levels of funding are negotiated and finally a tripartite, three-year agreement is signed between the multi-purpose service, the Commonwealth and State Governments (Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002; Lewis, 2004).

When the Multi-purpose Service Program began its objectives included:

- improving the flexibility of services;
- providing health and aged care services more cost effectively;
- improving the coordination of health and aged care services; and
- enhancing responsiveness of health and aged care services to identified community needs (Sach & Associates, 2000, p. 3; Hoodless & Evans, 2001).

Each of these objectives will be discussed individually, followed by a brief discussion of leadership issues specific to multi-purpose services. Table 1 summarises the literature related to multi-purpose services and addresses how well these objectives are met. In order to meet their objectives, Sach and Associates (2000) suggest multi-purpose services relied on principles of community involvement and ownership; local determination of priorities; a broader focus than physical facilities; and targeting local needs. However, literature related to multi-purpose services provided little information
about the experience of people who have been involved or how they moved through the
development, instead, dealing with the objectives that multi-purpose services were
designed to meet.

2.4.1 Flexibility of Services

One of the main objectives in developing multi-purpose services was to increase the
flexibility of health service provision to meet the diverse needs of rural and remote
Australia (National Health and Hospitals Reform Commission, 2009). Even individual
communities demonstrate diversity at different points in time, due to influences such as
climatic conditions which impact on the delivery of health services (e.g. roads which are
subject to flooding) and influxes of seasonal workers or tourists (which can increase
populations markedly for short periods of time) (Humphreys, 1998). Merging aged care
and acute care services as part of the multi-purpose service development was designed
to build on the complementarity of the existing organisations to provide a greater
variety of services than were previously available.

The Australian population is ageing and most people prefer to age in their own home or
at least within their own community (Scott, 2003). This desire to age within one’s own
community is reflected in the Aged Care Act of 1997 which includes a requirement to
facilitate access to aged care regardless of geographical location (NSW Ministerial
Advisory Committee on Health Services in Smaller Towns, 2000; Humphreys, Hegney,
Lipscombe, Gregory, & Chater, 2002; Neumayer et al., 2003; National Rural Health
Alliance & Aged and Community Services Australia, 2004). Although small rural
health services have frequently provided aged care services, their physical facilities and
staffing were frequently not appropriate for that purpose. To meet aged care needs
multi-purpose services have increased the flexibility of service provision and provided
the opportunity to attract capital funding (Reid & Solomon, 1992; Department of
Human Services (Vic), 1996a; Hartley, 2003).

services in New South Wales suggest that flexibility of multi-purpose services improved
mainly at the managerial level, without cultural change infiltrating through to lower
levels of staff. The success of using staff more flexibly was dependent on effective
education of all staff involved in the development of the new model of health service
delivery (Andrews et al., 1995; Mills, 1995; Mott et al., 1995; Duffy, 1997). A lack of
training in aged care and limited staff members with qualifications in that area were
found in some evaluations of multi-purpose services, together with a resistance by both
staff and communities to make the cultural change consistent with the multi-purpose
service philosophy (Hartley, 2003; Neumayer et al., 2003; Allen, O’Connor, Chapman,
& Francis, 2008). As education allows staff to provide appropriate care for their clients,
having a wide range of education is essential for staff to be flexible in the provision of
health care services.

There was a general consensus in the literature that flexibility of services had been
achieved in those multi-purpose services which were evaluated through flexible use of
beds and flexibility in meeting community needs (Andrews et al., 1995; Sach &
Associates, 2000; Hoodless & Evans, 2001; Neumayer et al., 2003). When health
services were able to meet the needs of their communities more flexibly there was an
assumption that the services would, in turn, be more cost effective than previously, by limiting services that were poorly utilised.

2.4.2 Cost Effectiveness

Distribution of funding based on broad regional data is frequently unable to address issues of isolation or small populations. Similarly distribution of funding related to casemix disadvantages those health services with small numbers of patients, frequently leading to a downgrading or closure of small rural hospitals. Both of these funding arrangements are often inappropriate to meet rural needs (Strasser et al., 1994; Brumpton & Thompson, 2000). Cost effectiveness was created in multi-purpose services through the ability to pool funding from different sources allowing it to be used in a more flexible manner, not necessarily in relation to the program to which it was allocated (Commonwealth of Australia, 2005). The ability to pool funding demonstrated the significant commitment of government departments to enhance local decision making (Evans & Hoodless, 1999; Hoodless & Evans, 2001; James, 2001). There was general agreement that the ability to pool funding produced a more cost effective approach to service delivery, allowing efficiencies in administration (Reid & Solomon, 1992; Brumpton & Thompson, 2000; Sach & Associates, 2000).

Several authors (Bailey, 1995; Mensink, 1995; Duffy, 1997; Lewis, 2004; Evans et al., 2006) described small rural hospitals with limited or threatened viability as those which had been targeted for the multi-purpose service model. Frequently cost effectiveness was portrayed as the main reason for a multi-purpose service development, which would ‘secure’ the future of health services within a community. Nursing homes were
perceived as being viable if they had twenty or more beds; acute hospitals if they had thirty or more beds (Reid & Solomon, 1992; Snowball, 1994; National Rural Health Alliance, 1996). Some small acute hospitals with viability issues were under pressure to justify their ongoing funding and may have admitted patients to keep up bed occupancy numbers, distorting the real need within their communities (National Health Strategy, 1991). The rural health and aged care services which were appropriate to be developed as multi-purpose services rarely had sufficient bed numbers to be regarded as ‘viable’. Combining two or more services of dubious viability had implications for the entire new organisation (Sach & Associates, 2000).

The multi-purpose service model provided flexibility in the management of funds, but it did not provide additional ongoing funding (Sach & Associates, 2000). Andrews et al. (1995, p. 19) in their evaluation of the Pilot Multi-purpose Services Program state that the multi-purpose service model was “not intended to either meet current unmet need or achieve program savings”. Any savings which were achieved would remain in the ‘pool’ to be used at the discretion of the multi-purpose service. For the majority of multi-purpose services their funding base relied heavily on the previous size of their acute health and residential care components. Multi-purpose services, which began with financial debts or inefficient organisational structures often led to a loss of services and/or staff restructuring. Attempts to reduce acute beds, even if they were underutilised, usually created a loss of community support. Frequently communities had financially supported pre-existing services, which led to a focus on retaining current services, rather than supporting a new and unconfirmed model of health service delivery (Sach & Associates, 2000).
Flexible funding in the form of pooling was not always problem free. In aged care, for example, the Commonwealth Government had ‘cash out’ residential care at average funding levels, which led to insufficient funding for those services with a greater than average number of dependent clients. Existing aged care facilities found average funding levels to be a disincentive to merge with the health service as the income they were capable of attracting for each client would be reduced. Some existing aged care facilities also feared that funds would be drained from aged care to meet acute care needs which were often perceived to require more immediate resolution than aged care needs (Andrews et al., 1995; Sach & Associates, 2000; National Rural Health Alliance & Aged and Community Services Australia, 2004).

Achieving savings in expenditure could be delayed by an impediment in facility redevelopment or when senior managers could not be recruited in a timely manner. The need for strategic planning was identified as a necessity in the government agreement to develop multi-purpose services, but actual planning occurred simultaneously with ongoing service delivery and required additional resources and management skills, which frequently did not exist within the small health service (Andrews et al., 1995; Sach & Associates, 2000). Sach and Associates (2000) recommended that transition funding be available to cover these and other initial establishment costs. When the Pilot Multi-purpose Services Program was implemented, a small amount of funding was made available to facilitate coordination; this was described as “an important ingredient for success” (Andrews et al., 1995, p. 60).
Some multi-purpose services attempt to function over multiple sites. Sometimes multiple sites were used due to a replication of the same type of health service in different communities, or different services (e.g. a hostel and a hospital). Due to their replication of staff and resources, multi-purpose services which attempted to function over multiple sites had particular difficulty achieving cost effectiveness (Sach & Associates, 2000).

Closing or downgrading rural hospitals threaten the viability of local general practices, due to their dependence on the hospital for income and professional satisfaction related to the scope of practice of the general practitioner (Reid & Solomon, 1992). Although Snowball (1994) denied that the development of a multi-purpose service would have any adverse affect on the local general practitioner, Keating and Calder (1997) affirm that the change in role from bed-based services towards home-based care would have significant financial and personal impacts on general practitioners.

In their national evaluation of seven pilot multi-purpose services, Andrews et al. (1995, p. 85) found that the flexibility of the multi-purpose service model of health service delivery had allowed all the multi-purpose services to ‘contain’ administrative and infrastructure costs within their budget allocation. A reduction in administrative costs frequently resulted from the merging of administrative roles, which may have improved the coordination of services.
2.4.3 Coordination of Services

The integrated model of health service delivery which was implemented in multi-purpose services aimed to improve coordination of previously stand-alone services. For those multi-purpose services which combined these services on a single site, some improvement in coordination was easy to achieve through improved access to each other. Some sites were able to implement a strategy of sharing staff from previously stand-alone services which also improved coordination of services (Andrews et al., 1995; Mensink, 1995; Brumpton & Thompson, 2000; Hoodless & Evans, 2001; Humphreys, Hegney et al., 2002).

Sharing staff between previously stand-alone services provided staff with an opportunity to experience broader roles than they had undertaken previously and encouraged multi-skilling (Andrews et al., 1995; Mensink, 1995; Brumpton & Thompson, 2000; Hoodless & Evans, 2001; Humphreys, Hegney et al., 2002). Standardisation of assessment and management plans which were suitable for use across the new service also assisted in coordination of services (Hoodless & Evans, 2001).

Sach and Associates (2000) found that a devolved organisational structure, rather than the previous hierarchical structure, empowered staff in multi-purpose services. Devolved organisational structures in combination with flexible hours, professional networking, staff training and development led to high staff morale and low staff turnover.

Although Humphreys, Hegney et al. (2002) agree that multi-skilling is essential in dealing with the complex and comprehensive nature of work in the rural area, they
argue that multi-skilling is inhibited by the difficulty in sustaining such expertise, and the health industry culture which dictates that successful practitioners specialise. Similarly, collocation of Ambulance Services may be part of the multi-purpose service configuration, but NSW Health (2001) warned that care should be taken to ensure existing staff roles were not adversely affected and that ambulance staff must not be used to fill clinical hospital vacancies.

Improved coordination of services is documented in multi-purpose service evaluations (Sach & Associates, 2000; Neumayer et al., 2003). Although several authors claim that coordination of care has improved in multi-purpose services, evidence for such statements is insufficient to determine its extent (Andrews et al., 1995; Sach & Associates, 2000; Neumayer et al., 2003). Improved coordination of health care services should eliminate the duplication of services and thereby improve the ability of that service to meet the needs of the community it serves.

2.4.4 Community Needs

Community consultation is viewed by the Australian Government as extremely important in both the development and ongoing management of multi-purpose services (Hoodless & Evans, 2001; James, 2001; Neumayer et al., 2003; Tonna & Lander, 2003; Australian Government Department of Health and Ageing, 2004; Australian Health Ministers’ Conference, 1994). Despite stating that consultation is important, the government has provided little clear understanding of what this might entail for multi-purpose services and have allowed regional or area health services to determine the most appropriate structure or mechanism to ensure community involvement in the
development. Increased coordination and flexible services should address community needs that were not previously being met. However, in order to ensure that services are responsive to community needs, community consultation must take place (Hoodless & Evans, 2001; James, 2001; Neumayer et al., 2003; Durey & Lockhart, 2004; Mills, 2008).

Communities and health services perceived the need for change differently, with communities requiring time to adjust to the new health care model. A community’s perspective often focused on the acute care services which were felt to be essential for the community’s safety; however, community utilisation of those services did not reflect the high value which communities placed upon them (Sach & Associates, 2000; Hoodless & Keating, 2002; Durey & Lockhart, 2004; Smith et al., 2004; Evans et al., 2006). Hoodless and Evans (2001) also pointed out that even though some services were more highly valued than others by community members, health care planning needed to focus on making the best possible use of resources to meet identified needs within the community rather than support inappropriate services.

Despite the positive attitude of the government to community consultation, some authors (Hoodless & Keating, 2002; Humphreys, Hegney et al., 2002) considered that consultation empowered the service provider rather than the community. In their national evaluation of seven pilot multi-purpose services, Andrews et al. (1995, p. 67), stated that “there was community endorsement of the concept before an application was made to become an MPS” at every site. However, other authors (Keating & Calder, 1997; Evans et al., 2006) who examined one of those seven sites, claimed that
community support was poor, with the multi-purpose service model being unclear at that stage (it was a pilot site) and the only alternative presented to the community was the loss or down-sizing of their hospital.

Transparency, a timely and accurate disclosure of information, is recommended in the development of multi-purpose services (Durey & Lockhart, 2004). Hall and Medley (2001) indicate that in Western Australia the Commonwealth and State Governments held a shared vision and presented a common front to all communities which enhanced their ability to disclose information. In contrast in New South Wales the Sinclair Report identified a practice of passing responsibility from the Commonwealth to the State and vice versa, due to unclear responsibilities in key areas, which made disclosure more difficult (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000). Dunn (1995) points out the effect which open lines of communication between multi-purpose services and the Commonwealth and State Governments can have on the development of multi-purpose services. He also mentions open channels of communication with other multi-purpose services and unions, and the recognition, celebration and publicising of successes.

Some authors (Brumpton & Thompson, 2000; Hoodless & Evans, 2001) recommend providing the community with sufficient education and information to allow the community to participate actively in decision making. However, Durey and Lockhart (2004) found such a blurring of consultation and persuasion that community choice became non-existent. Community consultation and needs analysis frequently developed
into education sessions which promoted the multi-purpose service model as a solution to any identified needs (Durey & Lockhart, 2004).

Capital incentives were often foundational to community acceptance of the multi-purpose service model, with community members often claiming that the model had been imposed upon them. The need for a single governance structure habitually required the dissolution of several community committees, creating the impression that services had been ‘taken over’ by the largest service, often State-funded acute services (Mills, 1995, p. 232; Sach & Associates, 2000, p. vii; Durey & Lockhart, 2004, p. 102; Evans et al., 2006, p. 155).

Community consultation has been identified as a key principle in the development of multi-purpose services (Hoodless & Evans, 2001; James, 2001; Neumayer et al., 2003; Tonna & Lander, 2003; Australian Government Department of Health and Ageing, 2004; Australian Health Ministers’ Conference, 1994). Several authors caution that superficial consultations could lead to a poorer identification of community needs and thus impact on the ability of the multi-purpose service to meet those needs (Hoodless & Evans, 2001; James, 2001; Neumayer et al., 2003; Durey & Lockhart, 2004; Mills, 2008). Similarly Durey and Lockhart (2004) caution that combining education with consultation often leads to the community feeling that they have been coerced into accepting the multi-purpose service model. Ensuring that multi-purpose services met their objective of addressing community-identified needs was difficult. In examining the success of multi-purpose services in meeting community-identified needs and other
objectives, the literature also discussed leadership issues with managers who were frequently held responsible for the success of the new model of health service delivery.

2.4.5 Managerial Issues

The multi-purpose service model is designed to provide one management structure for all health and aged care services which historically were independently managed. A single management structure creates great challenges, as previous management structures need to be replaced. Consistent with the literature on organisational management, managers in multi-purpose services were given the task of implementing the new model of health service delivery. Managers were responsible for ensuring that the objectives of the model were met – their managerial skills being crucial to the effective implementation of the development (Keating & Calder, 1997; Lewis, 2004; Evans et al., 2006). Issues related to leadership in multi-purpose services included an acute care focus, a poor understanding of what the multi-purpose service model entailed and a lack of leadership resources.

Evans et al. (2006) describe the development of a multi-purpose service as a significant health care reform designed to restructure the traditional acute care focus of rural health services into a flexible and integrated new model of health service delivery. However, frequently, the acute health service maintained control of the new multi-purpose service. This varied across States but added to the acute care focus of multi-purpose services, which was discussed earlier (National Health Strategy, 1991; Bidwell, 2001; Fine, Pancharatnam, & Thomson, 2005; NSW Health Department, 2005). For some small independent services, becoming part of a large area health service was perceived as a
reduction in flexibility and local decision making (National Rural Health Alliance, 1997; Durey & Lockhart, 2004).

Evans et al. (2006) also point out that there was little consensus about what a multi-purpose service actually was. This lack of knowledge in combination with an emphasis on flexibility enabled it to become whatever those in control wanted it to be. Andrews et al. (1995) argue that both the Commonwealth and State Governments were attempting to empower local communities by giving them autonomy and responsibility for decision making. However the desired effect was not always achieved due to a lack of skills or knowledge, with coordinators of multi-purpose services expressing a greater desire for support and information instead (Andrews et al., 1995).

Several other authors (Brumpton & Thompson, 2000; Sach & Associates, 2000; Humphreys, Hegney et al., 2002; National Rural Health Alliance & Aged and Community Services Australia, 2004) also identified a lack of leadership resources in many rural communities which would inhibit their ability to implement the multi-purpose service model. This lack of resources was apparent not only in the health workforce but also in the local community. A lack of leadership and resources is consistent with the broader literature view which contends that those communities with the greatest need of health services often have the greatest difficulty articulating that need (Eccles, 2002).

Difficulties with leadership became even more apparent if leadership changed during the development of the multi-purpose service. Changes in leadership frequently resulted in the development becoming protracted as steps were retraced and consolidation of the
new leader’s knowledge was required (Andrews et al., 1995). Sach and Associates (2000, p. 130) identified several skills in senior managers of multi-purpose services that were a key to success. They included:

- program knowledge (acute, residential aged care, home and community care, community health and other community service programs);

- management experience (financial, human resource management, industrial relations, service management);

- an understanding of the potential offered by the multi-purpose service model;

- an ability to translate that vision into reality;

- a community development perspective; and

- an entrepreneurial skill for attracting additional funding.

Generally multi-purpose services appear to be meeting the majority of their objectives, but areas for improvement are apparent. The perception that managers are responsible for the successful implementation of the new model of health service delivery places great importance on their role. Sach and Associates (2000) suggest that guidelines would assist managers in the development, implementation and monitoring of multi-purpose services and should include those issues related to the need to combine services in a merger situation. Research into the experiences of people involved in the development of multi-purpose services will provide an evidence base from which to develop such guidelines.
2.5 Canadian Similarities

The Canadian health system has followed a similar pattern, replacing small rural hospitals with ‘Wellness Centres’ (James, 1999), a process often justified by economic measures (Lepnurm & Lepnurm, 2001; Schuurman, 2006). When restructuring of small rural health services was proposed in Canada, a similar interest from community members became apparent, as they struggled to maintain their health services (Abelson, 2001; Lui et al., 2001). Lui et al., (2001) also describe prolonged resentment on the behalf of community members when small rural hospitals were closed, despite having no decline in health outcomes.

2.6 Summary

This chapter has described the benefits and limitations of organisational culture. As the development of multi-purpose services involves the integration of a variety of services, which often pre-exist the multi-purpose service, mergers were also discussed and it was indicated that culture is pivotal to the success of organisational mergers. As a culture is created by a group, obtaining the perspectives of a variety of participants (e.g. community members, managers and staff members) would be useful, but has not yet been studied in the context of developing multi-purpose services. Management research has identified several cultural issues which impact upon mergers, but their relevance to small rural health services has not been investigated.

A lack of research about the development of a multi-purpose service from the perspective of participants warrants further research in this area. Grounded theory is a
research methodology which examines specific social experiences from the perspective of participants and aims to understand how participants have dealt with the social experience. This focus on social experience makes grounded theory a suitable methodology for the present study where the participants’ culture will play such an important role.

The following chapter details constructivist grounded theory which was used to explore the experiences of participants who have been involved in the development of a multi-purpose service. Chapter Three will also describe the theoretical framework of symbolic interactionism.
CHAPTER 3. GROUNDED THEORY METHODOLOGY

The previous chapter described the literature relating to organisational mergers, organisational culture and cultural change providing a background to the limited literature about multi-purpose services and the change process which is involved in the development of such services. The literature related to multi-purpose services predominantly focuses on economic benefits rather than the perspectives of the people involved in the development. In an effort to expand the multi-purpose service literature, the present study specifically seeks to understand the experience of participants involved in the development of a multi-purpose service. Such an understanding can inform future developments as multi-purpose services continue to be introduced.

This chapter explains constructivist grounded theory which has been used to inform the present study and why it was considered an appropriate methodology for this research. Grounded theory has evolved over time, necessitating a description of the underlying paradigm, which guides the assumptions impacting on the study. The first authors to describe grounded theory, Barney Glaser and Anselm Strauss (1967), have developed it in different ways. These differences, together with the impact of other authors such as Charmaz (2006), potentially lead to some ambiguity associated with grounded theory and require an explanation of which approach has been selected and why. This chapter goes on to describe the theoretical framework underpinning grounded theory, highlighting the constructivist perspective and how this is consistent with symbolic interactionism. The following chapter, Chapter Four, will describe how grounded theory was implemented for the present study.
The underlying epistemology, ontology and methodology require clarification to acknowledge their impact on the study. Together the epistemology, ontology and methodology will describe the paradigm or framework of beliefs, which guides the study (Strauss & Corbin, 1998; Denzin & Lincoln, 2005; Bryant & Charmaz, 2007a; Holloway, 2008; Lincoln, 2010).

3.1 Paradigm

A paradigm is a basic belief system or ‘world view’ which guides the assumptions and beliefs of the researcher. Five paradigms for research have been identified: positivist, postpositivist, critical theory, constructivist and participatory (Guba & Lincoln, 2005, 2008). Each of these paradigms was considered in relation to the aims of the present study before a decision was made to use a constructivist paradigm.

As the present study involves the investigation of a complex and dynamic social experience together with the desire for understanding rather than measurement, the positivist paradigm is unsuitable (Wuest, Merritt-Gray, Berman, & Ford-Gilboe, 2002; Guba & Lincoln, 2005, 2008; Charmaz, 2006; Holloway, 2008). Postpositivism aims for objectivity with a belief in the existence of one reality where conflicting participant views would not be equally valued (Blumer, 1970; Patton, 2002; Guba & Lincoln, 2005, 2008); likewise this paradigm is also inconsistent with the intent of the present study and unsuitable. Critical theory is also unsuitable for this research due to its focus on transforming situations of oppression, as the social structure (the development of a multi-purpose service) at the focus of this research could be viewed as enabling.

Although grounded theory is often a starting point in transforming oppressive situations,
it is not normally an explicit goal (Wuest et al., 2002; Guba & Lincoln, 2005, 2008; Holloway, 2008). Lastly, participatory research is also inappropriate for the present study due to the retrospective nature of the study (Blumer, 1970; Patton, 2002; Guba & Lincoln, 2005, 2008).

Of all of the research paradigms, a constructivist perspective takes a relativist stance, where differing viewpoints of participants are equally accepted. Each participant’s reality of a situation or an experience is viewed as being true and different groups of people would experience their reality differently (Charmaz, 2006, 2008a, 2008c; Mills, Bonner, & Francis, 2006b; Holloway, 2008). Accepting multiple realities is important in providing a complete picture of the experience of developing a multi-purpose service. The constructivist paradigm was also selected as it took into account the researcher’s subjectivity (see Researcher Background in Section 3.1.2). The ontological and epistemological underpinnings of a constructivist perspective are described below to clarify the researcher’s perspective in this study.

3.1.1 **Ontology**

Ontology provides information about the nature of reality as perceived by the researcher (Denzin & Lincoln, 2005; Holloway, 2008). A constructivist perspective is based on the belief that although a physical reality exists, knowledge about that reality is socially constructed, allowing for the existence of multiple social realities (Charmaz, 2006, 2008a, 2008c; Mills et al., 2006b; Holloway, 2008). The social world is co-constructed through social iterations by individuals as they interact with the world. This leads to
subjectivity in an individual’s perception of their social reality which has real consequences in their lives (Patton, 2002; Clarke, 2005).

This belief that each individual constructs their own reality is also consistent with symbolic interactionism in which the meaning an individual attributes to their reality is socially co-constructed. Acknowledging that every participant experiences their own reality demonstrates a respect for each participant and their perspective. Respect for each participant’s perspective ensures that the researcher invests sufficient time in understanding the participant’s perspective and is willing to question their own beliefs if participant meanings conflict with their own (Charmaz, 2000, 2004, 2006, 2008b; Charmaz et al., 2007).

The aim of this research is to understand the experience of individual participants who have been involved in the development of a multi-purpose service and who experienced that development from their own individual perspective. The ontological position of relativism afforded by a constructivist perspective is essential for this study so that the individual experiences of the participants are acknowledged as reality and that it is possible for many individuals to experience the same reality differently. Having a constructivist ontological position also creates a necessity to discuss the epistemological position.

3.1.2 Epistemology

Epistemology is concerned with the nature of knowledge and describes the relationship between the researcher and knowledge; in particular, how the legitimacy of that
knowledge is determined (Keddy, Sims, & Stern, 1996; Denzin & Lincoln, 2005; Holloway, 2008). A constructivist perspective requires a researcher’s epistemological position to be interactive and subjective. This position stems from the researcher realising that complete objectivity is impossible and that knowledge is co-created through an interaction between the participants and the researcher themselves. Knowledge is, therefore, both provisional and contextual. Being provisional, knowledge is constantly being reassessed in light of further information and may continue to change into the future (Charmaz, 2000, 2003, 2006; Mills, Bonner, & Francis, 2006a, Mills, et al., 2006b). Knowledge is also contextual in that it is expected that each participant will have a different perspective or understanding of the context in which they are situated (Charmaz, 2000, 2003, 2006; Mills et al., 2006a, 2006b). It is not possible to separate the participant from their context and retain meaning, as participant actions are the result of the participant’s interpretation of their context (Charmaz, 2000, 2003, 2006; Mills et al., 2006a, 2006b).

The epistemological position of constructivist grounded theory allows for knowledge to be co-constructed through the interpersonal relationships between the participants and the researcher. A picture of the participant’s experience is then co-constructed through negotiation between the researcher and the participant. Knowledge is considered to be an interpretation rather than an objective representation of that experience. In the research process researchers are required to adopt a reflexive role in order to be aware of the impact which they as the researcher are having on the research (Charmaz, 2000, 2003, 2006; Mills et al., 2006a, 2006b). Grounded theory also advocates theoretical sensitivity (see Theoretical Sensitivity in Section 3.2.3) where a researcher does not
merely acknowledge their role in the research but actively uses their insight into the
experiences being studied to identify relevant issues and events in the data (Strauss &

The epistemological position acknowledges that this research is not undertaken in a
vacuum and the underlying beliefs and background of the researcher impact on both the
research question and design (Gergen, Gergen, & Lincoln, 2000; Charmaz, 2006,
2008c; Bryant & Charmaz, 2007b; Corbin & Strauss, 2008). In recognition of a
researcher’s background on a study, it is essential that I now provide an account of my
own background.

Researcher Background

As the researcher, I selected a paradigm which resonated with my own beliefs.
Constructivism acknowledges my inability as a researcher to totally separate myself
from this study and gives some credibility to my own reality rather than attempting to
disguise or bracket my own experiences.

My previous knowledge of and involvement in the development of multi-purpose
services afforded me some theoretical sensitivity to quickly develop a rapport with the
participants and to better understand those experiences being described during
interviews. My position in this research was that of someone who was familiar with
multi-purpose services. I had worked for several years in a health service, which was
redeveloped as a multi-purpose service. My involvement in the development of this
multi-purpose service enhanced my interest in the area and made me wonder how others
perceived the development. Despite the benefits derived from my background, I was constantly aware of the need to question my knowledge, how I had obtained that knowledge and was it the same as that of the participants in this study.

In anticipation of this research, I resigned from my position, three years prior to beginning interviews for this research, in order to remove real or perceived power dynamics between myself as a manager and staff which may have existed previously. I believe that this made the participants in this research less guarded in their interviews. I also used a journal to record my feelings about power dynamics and their effect on conversations during interviews.

I was able to contextualise some of the experiences which participants described due to having been involved in the development of a multi-purpose service for three years. This may have made participants more likely to accept and trust me in order to co-construct a shared understanding of their experiences. I acknowledged participants as experts in their particular context, for example: knowledge of their community, their experiences and their multi-purpose service. In my journal I also documented my own ideas and how they assisted with the co-construction of the emerging theory over the period of the study. Another technique I used was to include participants from several multi-purpose services in order to understand differences and similarities to the one that I was familiar with.

As an ‘insider’, I benefited by understanding the culture, professional jargon and organisational structure; this assisted in building a rapport with participants (Bonner & Tolhurst, 2002; Arber, 2006). During the research I did not self-disclose my own
experiences of developing a multi-purpose service but I did answer questions about myself honestly to encourage participants to identify with me and to establish rapport. For instance, I focused on aspects of my career that I felt participants could identify with, such as I disclosed to assistants in nursing that I had once been an assistant in nursing and to managers that I had once held that position. At all stages I tried to communicate to participants that I valued their opinions.

By acknowledging my background I aimed to clarify both its impact on the study and the importance of taking a relativist ontological position and an inter-subjective epistemological position. A description of the methodological position used in the study adds to this clarification by describing my assumptions about how reality is examined and knowledge attained.

3.1.3 Methodology

A hermeneutic and dialectic methodological position is taken in constructivist research (Denzin & Lincoln, 2005). The hermeneutic perspective attempts to interpret data from the perspective of the participant, taking into account their cultural contexts to better understand how different realities are constructed (Patton, 2002). The dialectic method compares and contrasts constructions of reality to address contradictions. Together the hermeneutic and dialectic perspectives combine to create an informed construction of that reality (Guba, 1990).

This study sought to examine the experiences of participants involved in the development of multi-purpose services. The individuals who were involved –
community members, managers and staff members – each had a different perspective of reality through their own experiences. Due to each person’s unique perception of reality, the only way to access this knowledge was to engage with each of these groups of people in order to portray their perspective and to afford each group an equal voice. To achieve this, a constructivist perspective was required. A constructivist grounded theory allows participants who have been involved in the development of a multi-purpose service to identify the issues that are important to them, rather than attempting to force a pre-determined theory onto their situation.

3.2 Grounded Theory

Grounded theory aims to generate theory from data. It is particularly useful in situations where little previous research has been undertaken. Grounded theory begins with a general area of interest and allows participants to describe those issues they find important, rather than to discover differences between groups. Constructivist grounded theory acknowledges the role of the researcher and the participant as partners in the co-construction of meaning. This results in an interpretive theory which is a portrayal of the area of interest rather than an exact copy (Charmaz, 1994a, 2006; Mills et al., 2006a).

The relevance of constructivist grounded theory to this study will now be discussed. A brief history of grounded theory will be provided in order to identify different perspectives on the method and to clarify how grounded theory was implemented in this study. This will include the differences between the two original authors, Barney Glaser and Anselm Strauss (1967) and indicate how these differences are addressed by Kathy
Charmaz (2006) in constructivist grounded theory. Finally the central features of grounded theory will be described.

3.2.1 Relevance of Constructivist Grounded Theory to this Study

Constructivist grounded theory allows the formation of a theory which reveals an understanding of social experiences while maintaining their complexity (Charmaz, 2006, 2008a). Grounded theory is a general method of creating theoretical frameworks to uncover the meanings and interpretations which participants hold, making it useful for research where little is known about a social experience (Glaser & Strauss, 1967; Glaser, 1992; Strauss & Corbin, 1998; Charmaz, 2006). As identified earlier, research relating to the development of multi-purpose services is limited (Andrews et al., 1995; Sach & Associates, 2000; Hoodless & Evans, 2001; Neumayer et al., 2003; Durey & Lockhart, 2004; Nicoll et al., 2004) and frequently focuses on the economic imperative of health service management (Andrews et al., 1995; Sach & Associates, 2000; Nicoll et al., 2004). Existing literature, however, provides little description of how the multi-purpose service model is developed from the perspective of the people involved. The development of a theory specific to the rural Australian context of multi-purpose services will enable relevant social issues to emerge and to illuminate what is happening in this context.

A grounded theory study commonly begins with a broad question (Corbin & Strauss, 2008). Data generation leads to the development of a provisional theory, which is examined against further data generation for interpretation and modification. Continued data generation and analysis lead to further modification of the theory. The theory
which is developed using this approach is ‘grounded’ due to the constant comparison that takes place between the data and the developing theory; the theory is directly related to the real-life experiences of participants (Glaser, 1978; Charmaz, 2006).

Unlike some qualitative methods, grounded theory has systematic, yet flexible, processes for generating and analysing data. Together these processes lead to a conceptual description of the participant’s experience being abstracted into a grounded theory (Charmaz, 2006, 2008c). The processes used in grounded theory have developed over time, necessitating a discussion of which developments have been implemented and how they relate to a constructivist grounded theory.

3.2.2 History of Grounded Theory

Grounded theory was initially developed by Barney Glaser and Anselm Strauss (1967) to build theory from data that accounts for patterns of behaviour which are relevant for individual participants. Glaser was influenced by Lazarsfeld’s quantitative methods, and Strauss was influenced by symbolic interactionism and pragmatism (Strauss & Corbin, 1990; Glaser, 1992; Strauss & Corbin, 1998). Glaser’s and Strauss’ understanding of and approach to grounded theory diverged after their initial joint development of this research method. More recently Charmaz (2006, 2008c, 2008d, 2008f), in particular, has written specifically about constructivist grounded theory and this guides the present study. A discussion about the differences between Glaser and Strauss follows to clarify how the current study was undertaken.
**Differences Between Glaser and Strauss**

In their first work Glaser and Strauss (1967) encourage flexibility in the use of grounded theory methods. Later, as they worked separately, their interpretation of grounded theory began to differ. Much of Strauss’ later work was undertaken in conjunction with Juliet Corbin. Some of these differences include the ontological and epistemological positioning of the seminal grounded theory authors, the necessity of developing a ‘theory’, and the research methods used.

Although never explicitly stating which paradigm grounded theory is situated in, Glaser and Strauss (1967, p. 68) felt that their original method ‘corrected’ for bias and controlled relativism. The researcher is described as demonstrating ‘informed detachment’ (1967, p. 226) and impersonal control over ‘data’ (1967, p. 48). These terms clearly indicate that the original grounded theory assumes a postpositivist, ontological and epistemological position.

Annells (1996, 1997) and Clarke (2005) suggest that Strauss and Corbin have changed their philosophical view from that of classical grounded theory and moved into a constructivist paradigm. Strauss and Corbin refer to a construction of reality rather than capturing a perspective of reality and advocate for the researcher to interact in the research, particularly in the use of experience to provide theoretical sensitivity (Strauss, 1987; Strauss & Corbin, 1990, 1994, 1998; Corbin & Strauss, 2008). Both of these features are more appropriate for a constructivist paradigm.
Strauss and Corbin (1998) acknowledge a variety of theoretical orientations in grounded theory, which can create some confusion (Annells, 1996, 1997; Charmaz, 2000; Locke, 2001; Clarke, 2005). In contrast Glaser (1978) has an objectivist view that a substantive theory will emerge without influence by the researcher, who should clear themselves of any and all preconceived ideas (Annells, 1997; Kelle, 2005; Charmaz, 2008d).

Constructivist grounded theory prioritises the experiences of participants over those of the researcher, the analysis and the method. It challenges the presumption that theory can be created independently of the researcher, acknowledging that any emergent theory is an interpretation which is co-constructed by the participants and the researcher (Charmaz, 2006, 2008a, 2008c). This prioritisation of participant experiences is the crucial difference that Charmaz (2000) identifies between objectivist and constructivist grounded theory.

Another difference between the seminal authors of grounded theory lies in the analytical techniques used to develop theory. Strauss and Corbin (Strauss, 1987; Strauss & Corbin, 1990, 1998; Corbin & Strauss, 2008) suggest an additional coding technique, called axial coding, which involves using a specified coding framework. Glaser (1992, p. 61) feels that axial coding will force the data into a preconceived framework, resulting in a conceptual description rather than a true grounded theory. Several authors (Glaser, 1992; Stern, 1994; Melia, 1996; Seale, 1999) have described the Strauss and Corbin use of axial coding to be prescriptive and formulaic. Others (Kelle, 2005; Charmaz, 2006) disagree suggesting that axial coding is useful for novices or those who prefer to work within a set structure. From a constructivist point of view, axial coding may limit what
Annells (1997) and Kelle (2005) point out that Strauss and Corbin have become focused on process. They provide the example where Strauss and Corbin (1990, p. 148) state that if the researcher does not immediately “find evidence of process in the data … either it’s there, but not recognised as such or there is insufficient data”. Glaser (1978, 1992, 2002b) on the other hand reiterates the directive from the original version of grounded theory that a problem emerges from the participants and their data, and that problem may not be a process at all. Here, again, a constructivist paradigm hesitates to restrict data to those codes which are pre-constructed and waits for the emergence of a problem or a process or both which is significant to the participants (Charmaz, 2006). The relationship between symbolic interactionism and grounded theory also creates disagreements, with Glaser (2003, 2005) in particular denying the significance of symbolic interactionism to grounded theory. What follows is an examination of symbolic interactionism and its relationship and relevance to constructivist grounded theory.

**Symbolic Interactionism**

According to Charmaz (2003, 2006, 2008b) the underpinning theoretical perspective for constructivist grounded theory is symbolic interactionism. Symbolic interactionism was first described by Herbert Mead who was influenced by pragmatism (Locke, 2001; Charmaz, 2006). Four ideas link pragmatism and symbolic interactionism together. First, reality depends on an individual’s active intervention; second, an individual
constantly tests the usefulness of their knowledge; third, objects are defined by their use; and fourth, the understanding of individuals must be inferred by their behaviour (Charon, 1995). The influence of pragmatism creates an emphasis in symbolic interactionism on the usefulness of understanding others and the objects they rely upon. It is apparent that constructivist and symbolic interactionist perspectives consistently reinforce the active role of an individual in constructing their reality (Charmaz, 2006, 2008e). The pragmatic nature of symbolic interactionism ensures that the present study while describing the understanding of participants will also produce a substantive theory which will be useful to inform practice.

Symbolic interactionism is based on the interaction between the self, the world and social behaviour (Blumer, 1969; Charmaz, 2006; Bryant & Charmaz, 2007b). The world consists of physical objects (e.g. buildings, equipment), social objects (staff members, community members) and abstract objects (emotions, morals). Symbolic interactionism relies on three premises:

1. individuals behave toward objects on the basis of the meanings that those objects hold for them;

2. this meaning is derived from the social interaction which individuals have with each other; and

3. these meanings are modified in an interpretive manner by the individuals involved to deal with those objects (Blumer, 1969, p. 2).
The meanings given to objects are not always consistent and can vary between individuals, situations and time. Despite their inconsistency, meanings are important, as an individual’s behaviour relies on their interpretation of those meanings, and the significance of those meanings develops through shared interaction. Shared meanings develop in groups of individuals as they align their meanings with other members of the group, enabling an understanding of each other (Blumer, 1969; Locke, 2001; Clarke, 2005). Blumer (1969) warns that group behaviour is only created by the separate behaviour of individuals. Particularly when change occurs, new situations arise for which existing group rules are inadequate and these situations require individuals to re-interpret the meanings of objects within their world in order to decide on the appropriate shared behaviour. The interrelatedness of world objects, individuals and their behaviour requires research to take place within the social world of the individual (Blumer, 1969; Locke, 2001).

As symbolic interactionism is concerned with meaning and action it involves the study of behaviour at both a symbolic and an interactional level (Locke, 2001; Charmaz, 2008b). Blumer (1969) describes a physical world that exists separately to the individual, but it is the individual’s interpretation of the meaning that world holds which dictates their social behaviour. In order to understand behaviour it must be examined in interaction; the context, its implications, the social forces and previous events contribute to produce definitions of self, group and shared meanings. The meanings attributed to objects by individuals are accessible through in-depth, open-ended interviews; observation alone cannot inform the researcher of the symbolic interaction that is taking place (Patton, 2002). This emphasis on meaning is consistent with constructivist
grounded theory, where the researcher studies how participants construct meaning in their specific context (Charmaz, 2000, 2003, 2006, 2008b). In the present study such a focus on meaning will promote an understanding of the experience and role of the participants in the development of multi-purpose services.

Due to the subjectivity of knowledge it was assumed that each participant in the present study would have different knowledge even about the same phenomenon; constructivist grounded theory allows each of these perspectives to be heard (Charmaz, 2006), making it a useful methodology with which to study this experience. An improved understanding of the development of multi-purpose services would be useful to inform people involved in future multi-purpose service developments.

3.2.3 Generating Data

In grounded theory, data generation and analysis take place simultaneously with each informing the other (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987; Charmaz, 1994a, 2006). For ease of description, however, each are described separately. From a constructivist perspective, data generation takes place as a mutual partnership between the researcher and the participants to co-construct an interpretation of their realities (Mills et al., 2006a). In acknowledgment of co-construction of data, the term data generation is used throughout this thesis rather than data collection; data collection implies obtaining data without the researcher impacting upon it, whereas data generation indicates the co-creation of data from all participants and the researcher. Grounded theory research enables the researcher to be flexible in their collection of data (Charmaz, 2006). Data generation in grounded theory commonly involves theoretical

**Theoretical Sampling**

In a grounded theory study, theoretical sampling directs data generation according to the development of the emerging theory and its categories rather than structural circumstances or validating a preconceived theory (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987; Charmaz, 1994b, 2006). In all grounded theory studies, the first episode of data generation requires the researcher to decide who to sample. The initial participant is therefore chosen on the basis of their experience of the phenomenon; namely they are purposely sampled. Purposive sampling is needed initially as there is not yet an emerging theory to inform the direction of data generation. Purposive sampling is then replaced by theoretical sampling as the first data is analysed; the analysis begins to provide a theoretical direction for future sampling.

Rather than sampling participants who are representative of the population, those who will provide a rich source of data are sought in a grounded theory study. Variables such as age, gender, race or marital status are not considered in theoretical sampling unless participants indicate they are important variables in the emerging theory (Glaser, 1978; Corbin, 1986; Strauss, 1987; Strauss & Corbin, 1998; Charmaz, 2006). Theoretical sampling, based on the emerging theory, assists in deciding which participants to sample (Glaser, 1978).
Theoretical sampling ensures data generation is conducted simultaneously with data analysis and that the sample cannot be predetermined (Glaser, 1978, p. 39). Data generation is flexible, focusing on making comparisons of people, places or events in order to discover variations; it is a cumulative task. The data generated (and analysed) previously points to who and/or what to sample next and this sample, with the data it generates and its analysis, then directs the following sample. Initially sampling and data generation are general in order to generate a broad variety of data, but over time the sampling and data generation become more specific as the emerging theory provides a greater depth of understanding (Strauss & Corbin, 1990, 1998; Charmaz, 2006).

Delimitation of a study normally identifies the limits, boundaries or scope of the research. In a grounded theory study, theoretical sampling ensures that there are no preconceived limits; the study is flexible and can respond to change or as ideas emerge (Charmaz, 2000). Grounded theory involves gathering the widest possible diversity of data rather than specifically searching for a ‘negative case’ as this could limit data generation to a framework of normalcy and deviance (Glaser & Strauss, 1967; Glaser, 1978; Clarke, 2005). Charmaz (2006) points out that in grounded theory sampling continues until categories are saturated, rather than according to a pre-determined sample size which in her words “may be very small.” This is confirmed by Goulding (1998) who states that “most studies achieve saturation between eight and 24 interviews.” Theoretical saturation in grounded theory occurs when no additional data can be found to develop categories any further and ongoing data generation does not lead to any new insights about the emerging grounded theory (Glaser & Strauss, 1967; Glaser, 1992; Charmaz, 2006). Together theoretical sampling and theoretical sensitivity
guide not only which participant will be interviewed but also the direction that those interviews will take.

Theoretical Sensitivity

Theoretical sensitivity refers to the ability of the researcher to be sensitive to the data and the emerging categories of the theory (Glaser, 1978, 1992; Charmaz, 2006; Mills et al., 2006b). Literature and professional and personal experience are important sources of theoretical sensitivity but the researcher should be sceptical and constantly check that the emerging theory is grounded in data (Strauss, 1987; Strauss & Corbin, 1990, 1998; Bryant & Charmaz, 2007b; Corbin & Strauss, 2008) and co-constructed with participants. Theoretical sensitivity is lost when the researcher commits themselves to a preconceived theory or categories (Glaser & Strauss, 1967). To ensure that the researcher’s interpretation is not privileged above that of participants, Strauss (1987, p. 11) suggests using a ‘triad’ of data generation, coding and memoing which will be discussed later (Section 4.3).

The theoretical sensitivity of the researcher grows during the research project and the increased sensitivity towards the emerging theory assists the researcher in theoretical sampling and subsequent theory development/elaboration. Increasing theoretical sensitivity means that previously generated and analysed data may yield further information as the insights and understandings of the researcher (i.e. theoretical sensitivity) evolve. In order to take advantage of this increased theoretical sensitivity, the researcher can return to previously generated data and recode (Strauss, 1987; Strauss & Corbin, 1998; Charmaz, 2000).
Theoretical Saturation

Theoretical saturation occurs when gathering new data about a theoretical category does not reveal any new properties for that category, nor does it reveal any new insights about the emerging grounded theory (Charmaz, 2006). In a grounded theory study when theoretical saturation occurs, sampling ceases (Corbin, 1986; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1998; Glaser, 2002b; Charmaz, 2006). Strauss and Corbin (1990, 1998) suggest three phases of saturation: when new data does not indicate the need for further categories; when each category is well developed; and when relationships between categories are grounded in data.

3.2.4 Data Analysis

Data analysis takes place concurrently with data generation in grounded theory (Glaser, 1978; Charmaz, 2006). Concurrent data generation and analysis allow the analysis to guide the direction of sampling and for data generation to inform the analysis. From a constructivist perspective concurrent data generation and analysis also allow input from participants in the interpretation of data. Data analysis in grounded theory includes open coding, constant comparative analysis, theoretical coding and memoing, and the identification of a core category and a basic social process (Glaser, 1978; Charmaz, 2006). The timing and importance of a review of the literature (Chapter Two) to the emerging grounded theory is also discussed in this section.

In grounded theory, the analysis of data from initial interviews guides the line of questioning in subsequent interviews in order to maximise the richness of the data being
generated (Strauss, 1987). Interviewing in grounded theory differs from in-depth interviewing techniques as the range of interview topics narrow to gathering data which is specifically related to the emerging theory (Charmaz, 2003). The processes involved in grounded theory analysis are open coding, constant comparative data generation and analysis, theoretical coding and memoing.

Open Coding

Open coding uses a line by line analysis so that as many codes as possible are revealed. An open frame of mind is maintained by the researcher and no preconceived codes are used. Line by line coding ensures that each participant’s data is critically and analytically examined (Glaser, 1978, 1992; Charmaz, 2006, 2008c). Some of the open codes which are developed consist of words or phrases used by the participants (‘in vivo codes’); this reflects their reality and keeps initial analysis close to the data. In vivo codes frequently describe the behaviours and actions which participants use to explain and resolve their basic social problems. As codes are compared to the previous data they are justified by their repeated presence in the data. Initially open codes are considered by the researcher to be provisional and are often modified as comparison with other data continues during the analytical process (Glaser, 1978; Strauss, 1987; Charmaz, 1994b; Glaser & Holton, 2004).

Charmaz (2000) recommends using ‘action’ codes to provide insight into an individual’s actions – what they are doing and what is happening. These ‘gerunds’ encourage analysis from the participant’s point of view, reflecting an insider’s perspective rather than an outsider’s perspective. Gerunds assist in keeping the
emerging theory grounded in the data (Charmaz, 2000). Throughout the process of open coding, data is compared with all other data; this is called constant comparative data generation and analysis.

**Constant Comparative Data Generation and Analysis**

Constant comparative data generation and analysis are fundamental features of grounded theory (Glaser & Strauss, 1967; Glaser, 1978; Charmaz, 2006; Corbin & Strauss, 2008) and involve the simultaneous generation and analysis of data to allow the identification and subsequent exploration of commonalities and irregularities in the experiences of participants. It consists of repetitively comparing one piece of data with all others that may be similar or different to conceptualise possible relationships between them, while remaining sensitive to the interpretations and meanings given to the experience by the participants. Constant comparative data generation and analysis begin immediately that data is generated (Glaser & Strauss, 1967; Glaser, 1978; Charmaz, 2006; Corbin & Strauss, 2008).

Categories (concepts) are more abstract than the data they represent. Open codes are subsumed into subcategories and categories by being grouped together by a higher level abstracted or conceptualised term (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998; Glaser, 2002a; Charmaz, 2006; Corbin & Strauss, 2008). Categories are described by their properties and dimensions. Properties consist of subcategories which describe the dissimilar data or characteristics of the category to which they belong. Dimensions also consist of subcategories and form the range of similar data which makes up each category (Corbin & Strauss, 2008).
As the description of each category emerges, constant comparison moves from comparing more data with previously coded data (i.e. open codes), to comparing data with the properties of each category. This comparison leads to an integration of the knowledge of the properties of each category and the conditions under which the experiences occur (Glaser & Strauss, 1967). When categories are well defined, theoretical coding begins.

Although sensitive to the interpretations of participants, grounded theory analysis compares large amounts of data, some of which may not be known to the individual participants and as such may uncover patterns of which the participants are unaware (Glaser, 2002b). Constant comparative analysis allows emerging interpretations to be reconstructed by continually checking their credibility, plausibility and trustworthiness against other interpretations (Strauss & Corbin, 1990; Charmaz, 2006).

Open coding and the constant comparison of data lead to the formation of categories. In order to integrate those categories into a theory, their relationships to each other are identified through theoretical coding.

*Theoretical Coding*

A grounded theory begins to form as continued interpretation and analysis of data occur. Theoretical codes are used to conceptualise how categories relate to each other (Charmaz, 2006). As the theory solidifies new data generation leads to fewer major modifications of categories. Modifications to the emerging theory begin to clarify and elaborate the theory, rather than create major change to the theory. During theoretical
coding, properties of categories that are not relevant to the emerging theory are identified and can be subsumed into others. A core category (see below) becomes obvious as its relationship with other categories is clarified and a coherent analytical story emerges. Uniformities in categories are identified and higher level conceptual labels assigned to them in order to describe them clearly but more succinctly (Glaser & Strauss, 1967; Charmaz, 2006). Corbin (1986) warns about making linkages among categories too soon as it inhibits category construction and development. Theoretical coding can be assisted by the researcher memoing their thoughts during this stage of the analysis.

Memos

Glaser (1978) describes memos as a core stage in the generation of theory. Memos are records of thoughts about codes, categories and their connections (Charmaz, 2006) and are used throughout the constant comparative analysis to note ideas and reflect, but they have no predetermined course (Locke, 2001; Mills et al., 2006a; Birks, Chapman, & Francis, 2008, p. 69). As the theory solidifies, memos become more abstract, complex, clear and accurate (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1998; Birks et al., 2008).

Charmaz (2006, p. 86) suggests two methods to assist in writing memos: clustering, a form of diagramming the properties of a category or process; and free-writing to get ideas on paper, with an open mind. Diagrams are useful when the researcher is overwhelmed by memos and needs an overview of the developing theory (Corbin, 1986, p. 117). Diagrams are abstract representations and need not contain all concepts from
the data, but rather focus on the major categories, and should be sufficiently logical so that they can be interpreted without a great deal of explanation (Strauss & Corbin, 1998, p. 140).

Core Category

Glaser (1978, 1992, 2002b) feels the central goal in grounded theory research is to determine the main area of concern for participants and how they would resolve it. The main area of concern is termed a core category. The flexibility of grounded theory allows participants to raise issues and topics which are important to them. Theoretical coding assists in revealing a core category that recurs frequently, links other categories together and describes most of the variation in the social experience being examined. The criteria of a core category include centrality, frequent occurrence, explanatory logic and consistency, sufficient abstraction, depth and explanatory power, and ability to explain variations (Strauss, 1987; Strauss & Corbin, 1998).

The core category is the main concern or problem of the participants and Glaser (1978, p. 94) advocates actively looking for it, but warns against forcing one out. Charmaz (2004, p. 981) also cautions against any assumptions that the researcher may hold of what is significant to participants. She suggests that participants often cannot state what is most problematic for them.

Sometimes two or even three core categories may appear, but attempting to produce a theory around more than one will often result in neither of them being fully explored. Selecting the core category is the first act of delimiting the theory, as only data which is
related to it is included in the theory. If categories do not fit they may possibly be subsumed under other similar categories, otherwise if they do not add anything to the theory they need to be dropped altogether. Similarly a major category should have several subcategories otherwise it should be demoted or developed further. If difficulties are experienced in determining which category is the core, Strauss and Corbin (Corbin, 1986; Corbin & Strauss, 2008; Strauss, 1987; Strauss & Corbin, 1990, 1998) suggest writing a storyline, using diagrams and reviewing memos.

**Basic Social Process**

When a core category includes at least two phases of a process which occur over time, it may be a basic social process (Glaser, 1978). Strauss and Corbin (1998) suggest that analysing data for process gives a theory a sense of life and they search specifically for it. Glaser (1992), however, indicates that a grounded theory is a study of problems and their processes. He goes on to suggest that the importance of the process must emerge. Charmaz (2006) encourages the search for action and process, but notes that a basic social process is in itself an interpretation, even when participants concur.

A basic social process will describe changes in the behaviours of participants and demonstrate the stages they progress through, connecting events together (Charmaz, 2000). Clarke (2005) argues for the possibility of several basic processes as individuals may have differing perspectives. A gerund (an action verb) can be used to label a basic social process as it suggests movement (Glaser, 1978; Fagerhaugh, 1986), but Glaser (1978, p. 108) cautions against their overuse as “they may mask a basic social structural condition”. Finally Glaser differentiates between a basic psychological process which
occurs in individuals and a basic social structural process which refers to changes in a social structure (Glaser, 1978).

**Literature Review**

In grounded theory a literature review is designed to integrate the theory that is constructed from data analysis with other literature, to demonstrate how it contributes to current knowledge and typically takes place in the saturation stage (Strauss & Corbin, 1998; Charmaz, 2006). Glaser (1978, 1992) warns against approaching the literature too early as it can contaminate the data with preconceived concepts. A constructivist grounded theory approach (Charmaz, 2006; Bryant & Charmaz, 2007b), however, agrees with Strauss and Corbin (Strauss, 1987; Strauss & Corbin, 1990, 1998) that all researchers bring a considerable background to a study, including an understanding of the literature. In order to avoid contamination with preconceived concepts, only a cursory review of literature related to culture and mergers was undertaken in the present study.

Chapter Two revealed a paucity of literature and previous research about the development of multi-purpose services, so this was reviewed in complete detail. The limitations of the available literature ensured that the literature review did not pre-empt any codes or categories identified during data analysis and subsequent theory development. Rather than deciding to undertake a grounded theory study and then doing a literature review, it was the scarcity of available literature which indicated the benefit of undertaking a grounded theory study. A detailed literature review of concepts which emerged from the data was undertaken when their properties and relationships with
other concepts had been identified in order to integrate the substantive grounded theory with existing literature (see Chapter Eight).

3.3 Evaluating Grounded Theory

A variety of perspectives and ways of evaluating a grounded theory exist, necessitating the need to explicitly indicate which criteria are being used to evaluate the present study. Charmaz (2006) indicates that different audiences will evaluate grounded theory studies in different ways and the criteria described here are suggestive rather than prescriptive.

Qualitative research is embedded in the real world context of the participants, illuminating each of their views rather than a single objective reality. Total objectivity is incongruous with the constructivist paradigm, which frames the present study. Unlike quantitative research, qualitative research occurs within a variety of paradigms and affords different world views which may make it unrealistic to find a single group of evaluative criteria to cover all of those paradigms (Chiovitti & Piran, 2003; Rolfe, 2006). In a constructivist grounded theory, Charmaz (2006) proposes that criteria of credibility, originality, resonance and usefulness be used to evaluate the trustworthiness of a grounded theory.

Credibility stems from a familiarity with the participant’s context and the provision of sufficient data which could include range, number and depth of participant experiences to demonstrate the claims being made in the grounded theory. Credibility relies on faithful descriptions or interpretations of the experience being studied. Conceptual
density and detailed description provide evidence of intimacy with both the context and
the experience of participants (Hall & Callery, 2001; Locke, 2001; Holloway &
Wheeler, 2002; Charmaz, 2006). An audit trail of decision making also assists in
demonstrating credibility (Holloway & Wheeler, 2002).

Originality relates to the independent origin of the concepts which have been created
and the ability of the theory to extend or refine current ideas (Charmaz, 2006). Charmaz
(2006) indicates that there are three major ‘strategies’ to claim originality in a grounded
theory study: an analysis of a new area; an original analysis of an established area; or an
extension of current ideas, but grounded theory can frequently claim to have contributed
through two or even three of those strategies.

Resonance, the third evaluation criteria, indicates that the grounded theory and its
categories portray a ‘full’ experience and make sense to the participants. Readers of the
theory should be able to imagine the particular situations which are described in the
categories. Detailed description also provides evidence of resonance together with direct
quotes from participants (Charmaz, 2006).

Finally, usefulness suggests that the grounded theory contributes to advancing
knowledge which can be used by participants in their environment (Charmaz, 2006).
This emphasis on usefulness reinforces the pragmatic roots of grounded theory
(Lomborg & Kirkevold, 2003) and requires a full description of the context in which the
present study has taken place to enable readers to determine the degree to which
findings might be applicable to their own context (Chiovitti & Piran, 2003).
3.4 Summary

This chapter has explained why a constructivist paradigm which is consistent with grounded theory is appropriate for the present study and resonates with the beliefs of the researcher. The ontological perspective of multiple realities is congruent with constructivist grounded theory as it enables a variety of perspectives to be sought, heard and interpreted. The epistemological stance of constructivist grounded theory is that of an interactive subjectivist, which acknowledges the need for the researcher to participate in the co-construction of understanding. The framework of symbolic interactionism is also compatible with constructivist grounded theory due to both prioritising the meanings participants give to their interactions (Charmaz, 2006). Several features of grounded theory have also been described to ensure clarity of how data generation and analysis were applied in this research. Finally research needs to be evaluated and the criteria proposed by Charmaz (2006) to evaluate constructivist grounded theory (credibility, originality, resonance and usefulness) have been detailed. The following chapter will describe how these features of constructivist grounded theory and evaluative criteria have been applied during the present study.
CHAPTER 4. APPLICATION OF GROUNDED THEORY METHOD

The aim of the present study was to understand the experience of developing a multi-purpose service from the perspective of participants who had been involved in these developments. The complexity of exploring social experiences and the meanings assigned to those experiences by participants necessitated a constructivist paradigm informing a grounded theory methodology. The previous chapter detailed the underlying paradigm which was used in the present study and explained how it relates to grounded theory.

This chapter discusses the specific application of grounded theory to the present study. Details of the research setting, participant selection, data generation and analysis will be presented. This chapter will also address the ethical considerations associated with the participants interviewed. The constructivist approach which was utilised, acknowledges the interactive nature of the role of the researcher in conducting research. In order to maintain consistency with this paradigm, the researcher will be discussed in the first person from this point onwards.

A fundamental principle of grounded theory which was followed in the present study was the simultaneous generation and analysis of data. For clarity, each is described separately in this chapter. This section begins with a description of the multi-purpose services which participants were involved in, to assist in grounding the data within their context. The chapter goes on to provide a description of how the data was generated and analysed. Examples will be provided from the data to demonstrate clearly how data generation and analysis took place.
4.1 Research Aim

The aim of the present study was to determine the experiences of participants involved in the development of multi-purpose services in rural New South Wales. The development of a multi-purpose service involves several different groups of people. It was decided at the beginning that at least three groups would be significant; these were community members, managers and staff members.

4.2 Context of the Study

The development of multi-purpose services in Australia began in 1991 with the Multi-purpose Service Program (Sach & Associates, 2000; Hoodless & Evans, 2001; National Rural Health Alliance & Aged and Community Services Australia, 2004). For the participants involved in this research, the multi-purpose service model of health service delivery was still new and innovative.

The 2005 Annual Report for New South Wales Health identified that there were currently twenty-two, multi-purpose services in this state. The area health service, which contained the majority of those multi-purpose services, was the Greater Western Area Health Service which had sixteen (NSW Department of Health, 2005). It was for this reason that the Greater Western Area Health Service was selected as the primary location for the present study as, by having sixteen multi-purpose services, it was anticipated that sufficient participants would be recruited.

Greater Western Area Health Service serves approximately 4.6% (305,440) of the New South Wales population, but covers 55% (444,586 km²) of the landmass (Greater
Western Area Health Service, 2007). Multi-purpose services are most suited to rural and remote areas, making them a popular model of service provision in rural area health services such as the Greater Western Area Health Service. The following map (Figure 2) demonstrates the size of the Greater Western Area Health Service in comparison to the other area health services in New South Wales.

Some of the managers who were interviewed had roles which included involvement with all health services within the area. Other than participants who were involved in area-wide positions, participants were recruited from a total of thirteen sites; eleven from the Greater Western Area Health Service and two from another area health service.
Locations which had been commissioned as multi-purpose services between two and seven years (1998–2003) prior to this research were included in the present study. This length of time aimed to ensure that the change in health service delivery was well understood by participants and yet would be sufficiently close in time to the experience being studied (development of the multi-purpose service) to allow participants to have a reasonable recollection of the events. As the Greater Western Area Health Service was created in 2005, this was rarely the area health service mentioned by participants.

The multi-purpose services in which participants were involved reflected the variety of configurations which were possible under the Commonwealth Aged Care Act 1997 (Section 49) (see Multi-purpose Services, Section 2.4). This included:

- hospitals which had converted acute care beds into residential beds;
- hostels which had been extended to accommodate acute care services;
- hospitals which had been extended to accommodate residential aged care services;
- sites where the hostel was approximately 1 km from the hospital, but under the same management;
- sites which had primary health care provided on a site several kilometres from the multi-purpose service site, but under the same management;
- sites where the ambulance service was on the same site as the new multi-purpose service, but under separate management; and
• sites which were built specifically to house the new multi-purpose service.

4.2.1 Selection of Participants

In addition to human ethics approval (see Section 4.2.3), members of the executive and relevant senior managers from the Greater Western Area Health Service granted permission for the study to take place within the areas for which they were responsible. In the present study health service managers were the main gatekeepers controlling access to participants. Health service managers of each multi-purpose service in the Greater Western Area Health Service were contacted by letter informing them of the study and requesting that they provide contact details for several possible participants. Several did not respond at all; some agreed to participate and introduced other participants, and one embraced the project and provided contact details for more than forty participants. During interview most of the participants referred to each other (as well as other people who were involved in the development) as ‘stakeholders’; therefore, this term is used throughout the thesis.

All participants were assured that choosing to participate in the study would in no way affect their relationship with the health service. All participants were able to speak English fluently, and had experience in the development of a multi-purpose service, either as a community member, manager or staff member. Ethical issues will be discussed in more detail later in this chapter (see Ethical Considerations, Section 4.2.3).

Initial participant selection was purposeful, directed by the formal and informal roles, positions or status a participant had in a multi-purpose service. Several roles were
identified for the unique knowledge held by their occupants, including community members, managers and staff members. For example community members often had insight into political lobbying that had taken place; managers had greater access to peer support than other groups did; and staff members had a greater insight into the impact that the multi-purpose service had on everyday health service delivery.

The initial data were generated from three participants who were part of a purposeful sample which was created on the basis of their knowledge and experience of multi-purpose service development. The first participant had experience in the development of three multi-purpose services as a staff member. The initial purposeful sample also included a manager and a community member. The manager was enthusiastic and indicated that she had a wealth of knowledge about the topic. The community member was selected due to the perception by her peers that she was a knowledgeable advocate for her community.

These first three participants were also used to identify a broader range of participants; a type of snowball recruitment technique (Fossey, Harvey, McDermott, & Davidson, 2002). This technique assisted in identifying further potential participants who had specific knowledge and may have been difficult to contact otherwise. Being introduced by previous participants also assisted with the establishment of rapport and enabled flexibility in the choice of participants while in the field (Johnson, 1990). The snowball technique was typically used when a participant was interviewed at a multi-purpose service and the participant then identified possible further participants who were also on site at the same time. While some participants were aware that they had referred other
people, only I was aware of the participants who had been contacted, and who had agreed to participate in the study. If another participant had made a referral, they were not informed if this second person had ultimately agreed to participate in the study. The snowball technique did not, however, determine participant selection.

After the original purposeful selection of participants, participant selection became theoretical, guided by the emerging categories which were identified through simultaneous data generation and analysis (Glaser & Strauss, 1967). The majority of participant selection was theoretical, in particular in the later stages as my theoretical sensitivity improved through constant comparative data generation and analysis. For example, when a participant described the issues which arose when a health service merged with a community-owned hostel, subsequent analysis and the emerging theory prompted the theoretical sampling of participants from multi-purpose services where a different type of merger occurred. Theoretical sampling was important in this instance ensuring that the resultant grounded theory did not overlook the perspectives of participants from different types of health service mergers.

Benefits for data generation and analysis arose when several participants who had been involved with more than one multi-purpose service development revealed their greater knowledge of variations in development than those participants who had only been involved in the development of a single multi-purpose service. The wider experience of these participants assisted with the efficient and effective saturation of categories.
4.2.2 Description of Participants

Participants in the present study had all been involved in the development of a multi-purpose service. Participants described stakeholders as including anyone who had the ability to make an impact upon the development of the multi-purpose service.

Three groups of participants were interviewed, but they were not homogenous groups and participants had frequently been members of more than one group in the past. Most participants lived in the rural location where they had been involved in the development of a multi-purpose service.

As the theory developed there was a suggestion by some participants that the most dissatisfied people may have left the organisation. Initially this group was assumed to consist of staff members, but it became obvious later that community members and managers had also resigned from their positions and were perceived by the current group members to have left due to the development of the multi-purpose service. To ensure the experiences of these participants were also understood, several participants, who had resigned from their roles, were interviewed, including three staff members, two managers and two community members. Table 2 summarises the participant profile in terms of gender and their current role in the multi-purpose service.

The community members who were interviewed included three men and three women; they were substantially older than workforce participants with an age range of 65 to 83 years. All of the thirteen staff members who were interviewed were women, and
### Table 2: Participant Profile

<table>
<thead>
<tr>
<th>Group</th>
<th>Positions Held at time of MPS Development</th>
<th>Number</th>
<th>Pseudonym</th>
<th>Gender</th>
<th>Current Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Community Members</td>
<td>Health Council Member</td>
<td>6</td>
<td>Aileen</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Multi-purpose Service Advisory Committee Member</td>
<td></td>
<td>Christine, Dorothy, George, Jeff, Peter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers</td>
<td>Ambulance Station Manager</td>
<td>11</td>
<td>Danielle</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Area Health Service Director of Nursing</td>
<td></td>
<td>Fiona, Helen, Jane</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Area Health Service Senior Planner</td>
<td></td>
<td>Julie</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commonwealth Manager of Rural Health Programs</td>
<td></td>
<td>Kim, Lee, Margaret, Mary, Ruth, Tracey</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Health Service Manager</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Hostel Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Nurse Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Members</td>
<td>Cleaner</td>
<td>13</td>
<td>Angela, Barbara, Bev, Donna, Elizabeth, Jean, Jenny, Josie, Kate, Lyn, Michelle, Sonia, Sue</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Nurse Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Community Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrolled Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>30</td>
<td></td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>
their ages ranged from 36 to 61 years of age. Of the eleven managers who were interviewed, nine were women and two were men; their ages ranged from 46 to 61 years. For the purpose of maintaining anonymity, pseudonyms were assigned to all participants. The two male managers were also given feminine names to ensure they were not recognised.

Participants were recruited from a total of thirteen multi-purpose services. Four participants (2 managers and 2 staff members) had been involved in the development of two multi-purpose services and two participants (1 manager and 1 staff member) had been involved in the development of three multi-purpose services. In addition some managers worked at an area level and had involvement in all of the multi-purpose services in the Greater Western Area Health Service. Some managers had resigned from positions in other area health services in New South Wales, where they had also been involved in the development of multi-purpose services.

4.2.3 Ethical Considerations

In order to ensure that ethical principles in research practice were upheld, approval for the present study was granted by the Charles Sturt University Ethics in Human Research Committee and the Area Health Service’s Human Research Ethics Committee before recruitment of participants commenced. When participants consented to be interviewed, data generation and concurrent analysis began.

A participant information sheet (Appendix 3) was produced explaining the aims of the study, the rights of participants, what would be involved for participants, and the
measures that would be taken to ensure anonymity and confidentiality of data. The
information sheet together with a consent form (Appendix 4) were mailed to health
managers at all multi-purpose services in the Greater Western Area Health Service and
handed to participants for distribution to potential participants. Prior to consent being
obtained, any issues or questions which participants had were addressed. I assured all
participants that participating in this research would not influence their employment and
that no one need know they were participating. They were informed that participation
was totally voluntary and that they could withdraw from the study at any time. Both
information and consent forms included my contact details and those of both ethics
committees.

Informed and written consent was obtained voluntarily from each participant prior to
their interview commencing. Consent included maintaining the anonymity of
participants, the tape recording of each interview and the dissemination of findings in a
thesis, journal articles and conference presentations. One participant agreed to be
interviewed with notes being taken, as she did not want a recording to be made.

Names and other identifying data were replaced with pseudonyms during transcription,
and only I was aware of which pseudonym was assigned to each participant. The
transcripts will be kept securely for five years in a locked filing cabinet in a locked
office in Charles Sturt University. No identifying details were retained in the transcripts;
this strategy was used to protect participants’ confidentiality.

The likelihood of potential harmful effects being experienced by the participants in the
present study were considered very unlikely, but all participants, including community
members, were offered counselling from the Employee Assistance Program accessed through the Greater Western Area Health Service, if it was required. In retrospect, the participants in the present study commented on the benefits of having had the opportunity to share their experiences and knowing that their participation may be of value to others going through the development of multi-purpose services in the future.

4.3 Data Generation

Concurrent data generation and analysis took place and this was used to guide the sampling of participants, although each is described separately for clarity. Data was generated via in-depth interviews over twelve months (October 2006 – October 2007) and consisted of a total of 28 interviews with 30 participants. Four participants were interviewed as pairs at their request. The outcome of the interviews was designed to provide an understanding of participant experiences. These two participants indicated that they had shared their experiences with another person and that I would best capture that experience by interviewing them together. Both of these situations occurred where I had organised to interview one person who then introduced and requested the inclusion of another person who shared their experience in the development of multi-purpose services. Data generation resulted in approximately twenty-five hours of digital recording and seven hundred pages of verbatim transcripts. The concurrent process of data generation and constant comparative analysis took over twelve months, during which time I immersed myself in the data, reading, re-reading, coding and interviewing before a core category emerged which led to the identification of a basic social process.
4.3.1 In-depth Interviewing

Interviews are often used in qualitative research because they provide flexibility and depth of data. In-depth interviews enable participants to discuss what they feel is important, allowing the exploration of a particular topic or experience (Strauss & Corbin, 1998; Charmaz, 2006). In-depth interviews are most suited for grounded theory and a symbolic interactionist perspective, allowing events to be described as they unfolded (Charmaz, 2003; Kvale & Brinkmann, 2009). In-depth interviews involve asking questions and listening actively to elicit a complexity of information from each participant. Participants are encouraged to freely articulate their views while the researcher remains focused on the topic (Kvale & Brinkmann, 2009; Liamputtong, 2009).

In-depth interviewing focuses on understanding the significance of participant experience from their own perspectives; it acknowledges that participants may assign different meanings to the same experiences and it values each participant individually. In-depth interviewing complements symbolic interactionism, which also focuses on how action and meaning are constructed. An initial invitation for participants to tell their story had the advantage of providing an exploration of their experience. Allowing participants to tell their story ensured that the meaning and explanation assigned by participants to their experiences were obtained (Glaser & Strauss, 1967; Glaser, 1992; Charmaz, 2003).

In constructivist grounded theory the participant is asked to describe their experience while the researcher listens and encourages this description to emerge. The focus is on
understanding the participant’s interpretation of situations, events and assumptions, and allows a co-construction of the emerging theory. The theoretical framework of symbolic interactionism also emphasises the need to explore the participant’s views, experiences and actions (Charmaz, 2006). Theoretical sampling guides both participant selection and interview questions progressively focusing on data generation as the theory matures.

Each participant chose the time and venue for their interview. Interview locations were most frequently at the participant’s workplace, but also included their homes and other places where they felt comfortable (e.g. local coffee shops or offices), and one interview was conducted on the telephone. Flexibility in data collection was required with this participant who requested to be interviewed over the telephone. This was consistent with the respect for each participant’s perspective which acknowledges the constructivist ontology which formed the basis for this research (Charmaz, 2006; Charmaz et al., 2007). This participant held an executive position in the area health service, so had a unique insight into the development of multi-purpose services. Her request that the interview be conducted by telephone was respected in light of the unique knowledge that she held. Each participant was considered to have unique insight into the development of multi-purpose services and I respected each of their wishes of where the interview was to be conducted. I interviewed all participants using prompts which were broad and open-ended. Interviews were adapted to explore issues arising from concurrent data analysis (Strauss, 1987). In later interviews questions were modified according to the emerging theory (Strauss & Corbin, 1990). Empathy and affirmation for the opinions and experiences of participants were expressed and
information provided when requested to establish a rapport with them. Hall and Callery (2001) indicate that without such a relationship, participants lack the confidence that the research will accurately represent what they find significant in their lives.

Participants were all keen to speak of their experiences. The open structure of the interview allowed the flexibility to explore unexpected issues. In-depth interviewing uses an egalitarian approach, attempting to maintain a balance of power, rather than the imbalance commonly associated with structured interviews where the researcher directs and limits the input of participants. In-depth interviewing is particularly suitable for grounded theory which focuses on the main concern of the participants. In keeping with the constructivist paradigm being used to guide this research, it was acknowledged that I as the researcher was unavoidably involved in the study and co-creation of the data (Charmaz, 2003; Mills et al., 2006a). In order to be transparent about my background and the impact this had on the interview process, I have provided a brief overview of my history in Chapter Three.

4.3.2 Initial Interview Questions

The interviews were in-depth, beginning with a few carefully framed questions, which acted as prompts for the exploration of the topic, but otherwise following issues of concern to participants (Kvale & Brinkmann, 2009). Initially participants were asked:

1. What is your understanding of why the multi-purpose service was developed?

2. Describe the changes that occurred as the multi-purpose service developed.
3. Describe how the culture of your work environment changed during the multi-purpose service development.

These questions were broad enough to encourage participants to provide long and detailed answers. They were piloted in the first interview with that participant’s opinion being sought to ensure that the questions were appropriate. Further questions developed during the conversation were probing (e.g. Could you tell me more about that?), confirmed information (e.g. So was that an example of success achieved through a trusting relationship?) and followed issues (e.g. What was the degree/type/quality of consultation which you were engaged in?) which were introduced by participants. During later interviews, questions were formed around the categories that had been identified by previous participants (e.g. Do you think that stakeholders trusted the area health service/other stakeholders/government representatives?). An interview guide was developed after the first interview had been analysed, but was altered for each subsequent interview. The first participant was re-interviewed at the end of the analysis and the substantive grounded theory was described to determine whether or not she also resonated with it. This final interview provided confidence that the theory was saturated and that data generation could cease.

The meanings participants assigned to their experiences could be confirmed during the interview as it was flexible, spontaneous and responsive to the individual context of each participant. A focus on meaning and action resonated with the underlying symbolic interactionist perspective and encouraged participant and researcher reflection on the significance of interactions described by participants. Interviews provided an
opportunity to identify each participant’s key issues, which could be probed with further questions during the interview. Those participants who were involved in more than one multi-purpose service development were also asked to contrast and compare their experiences at different multi-purpose services. The meanings which participants ascribed to those experiences could then be examined in light of different contexts, and participants were asked what they thought had created these differences (Charmaz, 2004). At the end of each interview, each participant was asked if there were any issues related to the development of the multi-purpose service, which had not been discussed. Giving participants the opportunity to add to their interview was designed to ensure that all issues relevant to the participants were raised and divergent perspectives discussed (Hall & Callery, 2001; Kvale & Brinkmann, 2009).

A small digital recorder was used to record each interview. It was placed unobtrusively near the participant at the start of the interview. Participants seemed to quickly ignore the presence of the recorder and focused on describing their experiences to me. Although note taking during interviews was recommended (Charmaz, 2003), this appeared to create hesitation in several participants, so was kept to a minimum (Kvale & Brinkmann, 2009).

I transcribed all interviews myself as this gave me the opportunity to be further ‘immersed’ in the data. Transcription occurred soon after each interview to allow data analysis to occur concurrently with data generation.

Interview transcripts were offered to each participant to read and provide comment on before analysis. This audit strategy provided participants with the opportunity to make
changes, clarify their statements or make an additional contribution. Although they had this opportunity, most participants were happy with the transcripts as they were. Only two participants requested minor grammatical changes which did not impact upon the information provided during the interview.

4.4 Data Analysis

As described previously in Chapter Three (Section 3.2.4), in a grounded theory study data analysis takes place simultaneously with data generation to inform and enrich subsequent data generation. The data gathered from each interview was analysed and conceptual categories were formed. Apart from the initial purposeful sampling, sampling of participants was theoretical, guided by the emerging theory which was expanded and confirmed with each participant subsequently selected (Glaser & Holton, 2004). Initially data generation took precedence, but as the study continued analysis began to dominate, with data generation becoming more focused through the emergent categories and theory (Glaser & Strauss, 1967; Charmaz, 2006).

Using a grounded theory methodology data analysis took place concurrently with data generation (Glaser, 1978; Charmaz, 2006). This meant that after the first three interviews every subsequent interview substantiated and enriched the initial data analysis which took place. The emerging theory was presented to subsequent participants to ensure that they recognised their own experience in the findings and they were encouraged to add their experiences which may have been overlooked. Co-constructing the emerging theory with participants in this way and returning to the original participant at the end ensured that participants resonated with the emergent
theory. After theoretical sampling was concluded three further interviews were conducted and confirmed that no additional theoretical insight or new properties of theoretical categories were revealed (Charmaz, 2006).

In the present study data analysis began with immersion in the data. All recordings of interviews were listened to several times; verbatim transcripts were read and re-read on numerous occasions. The following describes the specific application of open coding, constant comparative analysis, memoing and diagramming, theoretical sensitivity and theoretical coding used during the present study.

4.4.1 Open Coding

Open coding is fundamental to grounded theory, undertaken with an ‘open’ frame of mind – without any prior assumptions about what may exist in the data (Glaser, 1992). In the present study, interview transcripts were read, reflected upon and re-read several times, so that I had an intimate knowledge of their content.

Initial fears of being influenced and limited by a computer program, led to attempting several methods of coding; namely, paper based and with word processing by computer, but each of these was cumbersome and made it difficult to keep track of data. Using a computer program (NVivo 2) improved my ability to manage large amounts of data and assisted with providing a record of data analysis.

Initially the first five transcripts were analysed in collaboration with my supervisor in order to understand the process of open coding. Each sentence or incident was coded into as many open codes as possible; these codes were of sufficient length to make their
context obvious. Table 3 provides an example of open coding. Open coding was used to ensure that as many meanings as possible were uncovered in the data, even though this resulted in the same or very similar data being coded in more than one category. The line by line analysis of all interview data resulted in a large number of codes, with initial labels reflecting the reality of the informants. The large number of codes uncovered in this first stage of analysis indicated the complexity of the experience of developing a multi-purpose service and how it could vary in different contexts.

Table 3: Example of Open Coding

<table>
<thead>
<tr>
<th>Data</th>
<th>Open Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think for a lot of registered nurses the idea of the MPS was quite scary because we see that as a numbing down or dumbing down of the skills that they once had, that they’re going to lose</td>
<td>Dumbing down of skills</td>
</tr>
<tr>
<td>I mean those nurses that really wanted to keep those skills up, well they will leave</td>
<td>Skilled staff will leave</td>
</tr>
<tr>
<td>And the other nurses that are happy to care for aged care clients as their core business well then they have continued to stay on</td>
<td>Aged care staff will stay</td>
</tr>
<tr>
<td>There were registered nurses there that were happily there for many years that ... and I go there now and they’re all new faces and I think a lot of those new faces aren’t registered nurses, they’re AINs and enrolled nurses (Kate, Staff Member)</td>
<td>Changing staff skillmix</td>
</tr>
</tbody>
</table>
resolving this loss of skills. She indicated that staff members were leaving the facility in order to maintain their skills.

At the open coding stage, the analysis focused on action, with some codes indicating what was happening – gerunds, for example: ‘dumbing down’. One question being asked of the data was ‘What is happening here?’ The other main question being asked of the data was ‘What does this mean to the participants?’ Questioning the data ensured that not only was coding descriptive, but it also focused on understanding. These two questions led to a comparison not only of events, but also of meanings which were assigned to those events by the participants.

4.4.2 Constant Comparative Analysis

Constant comparative analysis is also a fundamental feature of grounded theory and assisted in the development of conceptual categories of data (Glaser, 1992; Charmaz, 2006). In grounded theory a concept describes a social pattern. Social patterns are discovered through constantly comparing incidents to the codes generated in the open coding stage of analysis. The names of these social patterns are constantly compared to new data to ensure that they best describe those patterns (Glaser, 2002a; Charmaz, 2006).

Initially I considered all data to be of equal theoretical importance, but, as analysis progressed, and immersion in the data took place, those codes which offered greater theoretical explanation were identified. Line by line coding indicated which data was significant for more than one participant and through constant comparative analysis the
saturation of categories developed. Constant comparative analysis involved comparing data to develop an insight into what data were similar or different, and combining or differentiating categories according to these insights.

The example provided below (Table 4) demonstrates how I combined several codes into a conceptual category. Data which had been coded as ‘changing staff skillmix’ was limited to a description of changes which were occurring in the multi-purpose service as one type of staff member was replaced by another. When compared to other codes in the data (e.g. ‘lack of staff leading to roles changing’), similarities were identified. Eventually, several codes which described the development of new skills were conceptualised as part of the category ‘multi-skilling’.

Table 4: Example of Building Categories

<table>
<thead>
<tr>
<th>Open Code Title and an Example</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing staff skillmix</td>
<td></td>
</tr>
<tr>
<td><em>They have an AIN [Assistant in Nursing] to replace that EN [Enrolled Nurse] and no matter how good that AIN is, she does not have that knowledge of what an EN does</em> (Donna, Staff Member)</td>
<td></td>
</tr>
<tr>
<td>Lack of staff leading to roles changing</td>
<td>Multi-skilling</td>
</tr>
<tr>
<td><em>There wasn’t even a doctor ... so we were doing everything over the phone</em> (Bev, Staff Member)</td>
<td></td>
</tr>
<tr>
<td>Developing confidence in new role</td>
<td></td>
</tr>
<tr>
<td><em>Probably in the last ... three or four years, I’ve really ... I don’t know, become confident in myself I suppose and I’m happy to go into casualty and I’m happy to be left there with a chest pain and or a ... car accident or anything</em> (Donna, Staff Member)</td>
<td></td>
</tr>
</tbody>
</table>
Constant comparative analysis also allowed me to compare data provided by participants from the different groups, namely, community members, managers and staff members. At a superficial level each group’s involvement in the multi-purpose service development seemed different. It became clear during constant comparison that underlying the original open codes were broader, more abstract concepts. As constant comparison continued, categories which were initially relatively simple and descriptive progressed to become conceptualised: more inclusive of and descriptive of more data.

Initially I kept each group’s data separate from the others. Eventually, as more data was generated and compared, some similarities became apparent and categories were formed across groups. For example, managers expected to influence the development of the multi-purpose service and, through comparison of data from managers and community members, it became apparent that many community members also expected to be influential. Variations in the data indicated that an opposite also existed – a lack of influence. I then explored further by closely examining the staff member data to ascertain whether having influence also existed in that data. Staff members made it obvious that their opinions were frequently overlooked – a lack of influence. While constant comparison was being used in the analysis, theoretical sampling was used to locate any staff members who had been influential in the development of the multi-purpose service. I located and interviewed two staff members with specific experience of having been influential.

Categories were labelled to identify concepts in the emerging theory and NVivo 2 assisted with recording the definitions for each category. The labels of categories were
initially provisional and often revised, as more data was generated and further analysis took place. Similarly data was often moved from one category to another and many pieces of data were placed in more than one category. Later, during the analysis, several categories were merged or collapsed into a broader category and these categories were expanded to be more representative of the data which I had assigned them. Early interviews added to the number of categories which were emerging from the data, but later interviews only added depth to the description of each category. Constant comparison was assisted through the use of memos.

4.4.3 Memos and Diagrams

A journal was kept to record my personal thoughts and feelings during the study. In the early stages of the study, the journal recorded conversations with peers and experts. Later the journal was expanded to include field notes written after interviews were conducted. Field notes included descriptions of the towns where the multi-purpose services were, the multi-purpose service itself, the participant and the interview. Sometimes journal entries were directed towards participant selection, interviewing, or data analysis. The following excerpt from my journal (Table 5) describes a participant and the realisation that something which was initially considered to have been a ‘drawback’ (the participant had not been involved in the entire development of the multi-purpose service) could actually have more value and provide greater depth to the data. I used this journal entry to recognise that a social process was being described by this participant, which then directed future (theoretical) sampling towards other participants who had not been involved in the entire development.
Table 5: Example of Field Note

Kim was only involved in the initial stages of the multi-purpose service development, but having not been there for the entire development her memory of what had happened seemed to have a clarity which was not there in those who had been through the entire development. Even my own memories of the development I was involved with are somewhat blurred – it’s hard to say what order things happened in, or whether they were influenced by other things. Maybe those participants that were involved in the entire development don’t want to talk for too long – so they do not provide as much detail – just skimming over the entire experience, whereas those participants (like this one) that were only there for a small amount want to talk about it, but must remember more details to fill in the time. Maybe I need to focus my questions, so that I’m not trying to get them to talk about their entire experience … but still give them the opportunity to talk about what they think is important. I might try to find some more participants who had less involvement. Kim was involved at the beginning, I might try to find someone who became involved at the end …

In addition to the journal entry described above, memos were created within the NVivo 2 software allowing easy identification of supporting data and supporting the iterative nature of grounded theory (di Gregorio, 2003). The memos which were created alter over the course of analysis reflecting the abstraction of coding. A memo related to a discussion of the economic issues portrayed by a community member is provided as an example (see Table 6).

Table 6: Example of Memo

Dorothy describes a community which felt it had been blackmailed into becoming an MPS. She believes they were refused nursing home places for their new MPS unless the hostel ‘comes on board’. She discusses the ownership which the community had developed by working together to raise money for this hostel in the past. Now she feels they were being forced to sell it to the health service for a ‘peppercorn’. Dorothy talks about fighting for the hostel, but losing that fight to the government – unless they give up the hostel they won’t get nursing home funding. She feels that losing the hostel was about power and control, because it had been working well previously, so she can’t see that the government have gained anything in taking it over.

Becoming an MPS is being driven by money in this data. The people, who control the money, make the decisions; they have power. Offering money convinces the community to have an MPS.
When open coding had been completed, the use of diagrams became more useful to assist in developing the properties of categories and the links between them. Figure 3, an example of an early diagram, illustrates how the three groups overlap with some participants being part of two groups or even all three groups at times. Interaction follows the arrows, with staff being somewhat isolated. Staff interaction with community members is very limited and they do not interact with the government. The government is distant from the multi-purpose service, not only geographically, but also in its engagement in the development. The government is in a ‘superior’ position (hence it is at the top) due to its ability to make decisions and provide funding. It is not differentiated into State and Commonwealth because participants rarely know which government body they are referring to. Peer support is also significant for each of the groups – this is where they get information and encouragement. Information gives them power, allows them to anticipate the reactions of others. Encouragement keeps them engaged, reassures them that they have a worthwhile role. This diagram helped to clarify relationships between groups. As analysis progressed, it became apparent that the category of peer support (which developed into a property later) was not the only one which engaged people involved in the development of the multi-purpose service. The ability to draw on participant quotes easily through the use of the software package assisted in linking their words to memos and ensuring that memos and diagrams were clearly grounded in the data that drove them.
4.4.4 Theoretical Sensitivity

My background as a staff member and manager in the development of a multi-purpose service provided some understanding of the experiences being described, assisted with developing theoretical sensitivity and enhanced my ability to develop rapport with participants. Hearing of their experiences enhanced my own understanding of what occurred during the development of multi-purpose services and this in turn further assisted with theoretical sensitivity.
Reflexivity

My initial interview was with a colleague who also had previous research experience and understood qualitative interviewing techniques. I invited her to critique the interview and, on the basis of her suggestions and those of another expert advisor who read the completed transcript, I became less formal with my questions, adopting a more ‘conversational’ style of interviewing. An initial analysis of this interview revealed my colleague to be a key informant. She had experience working at multi-purpose services in three locations throughout their development and analysis indicated several codes that would later be abstracted to properties of major categories. The value of this interview was obvious and after discussion with her and my supervisor we decided that it should be included in the data. I attempted to monitor what I was saying in each interview conversation to ensure that the opinions of participants were valued, and I remained alert for new topics of discussion which were introduced by participants, to ensure that anything new was followed up. I continued the process of reflecting on each interview after it was completed and discussed the first five with my supervisor, who was an experienced researcher, to develop my skills in interviewing.

Data analysis also changed over time. Initially it was focused on events and the physical features of the multi-purpose service, but again with assistance from my supervisor I began to look for greater depth in my data. Looking for greater depth led to the exploration of underlying meaning in order to better understand the experiences being described. The first five interviews were coded separately and discussed to reach a shared understanding, and these discussions continued on a regular basis.
Analysis of data influenced data generation with initial categories directing questions in following interviews. Each interview was followed by analysis, but as more interviews took place I began to ask participants about their interpretations and whether the emerging theory had resonance with them. As the interviews progressed, fewer alterations and additions were suggested to the theory and in my final interview I returned to the first participant and presented the emerging theory to her to ensure that she also agreed with it.

During the course of the present study the emerging theory was presented to a number of health professionals (Anderson & Grootjans, 2007a, 2007b; Anderson, Grootjans, & Bonner, 2009) and to other students. Feedback from those familiar with multi-purpose services particularly resonated with the emerging theory. These presentations were significant in building my confidence that the experience of the participants in my study was of significance and interest to people other than the participants themselves.

4.4.5 Theoretical Coding

Through constant comparative analysis open codes were formed into categories, and gradually definitions and descriptions of the categories were clarified and became more detailed. Theoretical coding was then used to establish relationships (or conceptual links) between categories (Glaser, 1992). In the present study, diagramming was used to assist with visualising the relationships between categories. During theoretical coding the data was reorganised, numbers of categories were reduced and subsumed into new larger categories. Eventually three large categories (driving change, engaging with stakeholders and collaborating) emerged; each of these had greater explanatory power
and encompassed several ‘smaller’ categories. These three large categories became the basic social process as they were progressive and followed each other in a particular order. Despite participants usually moving through these categories in a specific order, their boundaries were seen to be blurred at the transition from one into the next. For this reason it was decided to call these categories ‘phases’ rather than stages or categories.

The ‘smaller’ categories which were subsumed into the major categories (phases) frequently became ‘properties’ of those phases. A property describes dissimilar features or characteristics of the category. For example, the phase of *driving change* subsumed categories of ‘recognising the need for services’, ‘economic issues’ and ‘ownership’ which were then conceptualised as properties of that phase.

When theoretical coding was complete a core category was identified (*Anticipation of Risk*) which was significant in each of the phases and was unable to be conceptualised as part of the progression. Instead it seemed to weave through the phases and link them together. The core category was described by participants as having two properties: judging motive and controlling risk. A dimension was also identified for the core category *Anticipation of Risk*. A dimension describes similar features or a range within the category, in this case a range of trust or suspicion was described by participants.

*Core Category*

The category of *Anticipation of Risk* recurred frequently and linked much of the data together due to its centrality. All participants described some *Anticipation of Risk* and it was this anticipation which linked their progression through the three phases of the
basic social process. Coding was then delimited to properties and dimensions which were related to the core category and enhanced saturation of the core category (see Chapter Five).

Basic Social Process

Grounded theory frequently identifies a basic social process (Glaser, 1978; Cutcliffe, 2005), in this case integrating rural health services with phases of driving change, engaging with stakeholders and collaborating.

The identification of the basic social process took several months of data analysis and the phases involved in the process emerged first. The boundaries between the phases were not pronounced with participants moving progressively rather than suddenly from one phase to another. The process at various stages of conceptualisation was presented to participants, other students and supervisors to provide advice on how it could be framed.

4.4.6 Theoretical Saturation

Theoretical saturation occurred when no additional data was found to develop categories any further and ongoing data generation did not lead to any new insights about the emerging grounded theory (Glaser & Strauss, 1967; Strauss, 1987; Glaser, 1992; Charmaz, 2006). Categories were seen to be theoretically saturated when new data did not reveal new properties of the category; they were completely developed and relationships between them were clear. Theoretical saturation minimises missing
important categories and ensures that the developing theory is rich and dense (Glaser & Holton, 2004). It is at this point that data generation should cease.

When theoretical saturation was thought to have occurred, three further interviews (one of each participant group: community member, staff member and manager) were undertaken and set aside (a ‘hold out’ sample). These three additional interviews were analysed after the substantive grounded theory (i.e. core category and basic social process) was conceptualised. Unlike open coding where codes emerged from the data, analysis of the ‘hold out’ sample used the preconceived codes (i.e. the core category and the phases of the basic social process) which had emerged during the earlier analysis. The preconceived codes also included searching for properties, dimensions and subcategories. The data from these interviews provided no property development and did not identify any new categories. This confirmed that saturation had occurred. However, these interviews enabled confirmation of the shared experiences articulated by previous participants providing additional illustrations of existing codes. According to Charmaz (2006) this data confirmed the data within the categories which had been developed and made them more robust. These ‘hold out’ samples confirmed the resonance of the substantive grounded theory with a unique data set rather than the data set which was used to build the theory. After this analysis of hold out samples, the first participant was approached and the theory was presented to her. She also resonated with the theory.
4.5 Data Management

NVivo 2 (QSR International, 1999) is a software program which was used to manage the data and to expedite the mechanical tasks of data analysis; it has the flexibility to change codes or recode at any time, while providing systematic storage and retrieval of the large volumes of data that had been generated (Basit, 2003). The speed at which data could be accessed freed time for analysis of the underlying meaning contained within the data. Although the data was coded, its context was maintained through frequent referral to interview transcripts and links with other codes, categories and memos which were all readily accessible through the software program. The use of NVivo 2 as a management tool assisted in providing evidence that saturation had been reached when new data no longer altered the categories and no data was left uncoded.

4.6 Evaluation of the Study

The previous chapter described the criteria proposed by Charmaz (2006) for evaluating grounded theory which were credibility, originality, resonance and usefulness. Each of these criteria will now be discussed in relation to the present study.

Credibility or truth value is determined by faithful descriptions or interpretations of the experience being studied, allowing categories to emerge from the data analysis rather than being imposed upon the data. Credibility was improved by prolonged data generation and the grounded theory method of checking that categories within the data were replicated by multiple participants (constant comparative analysis). The audit trail
and inclusion of data extracts in the presentation of the theory (Chapters Five, Six and Seven) provide insight into the method used and credibility of the study.

Originality is the requirement to add fresh, new insights to the current understanding of the social experience being studied (Charmaz, 2006). The findings and the substantive grounded theory revealed in this study will be discussed with existing knowledge found in the literature to reveal this study’s original contributions to knowledge. A major feature of this research is that the experiences of participants involved in multi-purpose service developments have not been previously researched making this an original piece of research.

According to Charmaz (2006) other people, including the participants who recognise their experience within the findings, demonstrate the resonance of a grounded theory. The participants, together with my own theoretical sensitivity, assisted to guide the data generation. Preliminary codes were often in vivo codes keeping initial data analysis close to the data which also enhanced resonance (Charmaz, 2006).

The final criterion of usefulness relates to the understanding which is created through the development of a substantive grounded theory. An improved understanding will facilitate possible changes in practice. In the present study usefulness is addressed through the recommendations provided in the final chapter, which suggest how the results of the present study can be applied to practice.
4.7 Summary

This chapter has extensively described the research methods used to generate and analyse data for the current study. Theoretical sampling to select participants followed initial purposeful sampling. Data generation involved interviews with thirty participants – community members, managers and staff members – who had been involved in the development of multi-purpose services within the Greater Western Area Health Service. Data generation proceeded concurrently with data analysis until theoretical saturation had been reached. Using grounded theory methods of open coding, constant comparative analysis and theoretical coding, a substantive theory of this experience was developed, which was driven by and encompassed the shared meanings of the participants.

The following chapter describes the core category and provides examples from the data to ensure a rich description of the main concern of participants. Subsequent chapters describe the phases of the basic social process and the substantive grounded theory. Chapter Eight will then discuss the substantive theory and how this relates to current literature. Chapter Nine will conclude and discuss recommendations for policy, practice, education and research.
CHAPTER 5. ANTICIPATION OF RISK

In the previous chapter the application of a constructivist grounded theory in this study was described. This description included how theoretical sampling was conducted, data generated and data analysed. Examples from the emergent grounded theory were provided to demonstrate how data generation and analysis were achieved.

A significant finding in the data analysis was the emergence of the core category, *Anticipation of Risk*. The core category was so significant to participants that it will be the first of the findings to be discussed. The core category was described by participants as having two properties – judging motive and controlling risk – and the dimensions of *trust* and *suspicion* (see Table 7) which will be described in greater detail in this chapter. *Anticipation of Risk* was central to the substantive grounded theory, ‘Developing a Collaborative Rural Health Service Identity’, a three-phased social process which will be described in the following chapter. The entire grounded theory including the core category and the three phases will be discussed in Chapter Seven to ensure that their relationships with each other are clear.

**Table 7: Properties and Dimensions of Anticipation of Risk**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judging motive</td>
<td>Trust</td>
</tr>
<tr>
<td>Controlling risk</td>
<td>Suspicion</td>
</tr>
</tbody>
</table>
The data generated in this study revealed that participant behaviour was framed by constructs that could be grouped under a category which has been labelled *Anticipation of Risk*. *Anticipation of Risk* was the main concern for all participants involved in this study and was central to the emerging theory, making it the core category of the basic social process of ‘Developing a Collaborative Rural Health Service Identity’. *Anticipation of Risk* was implicitly revealed by participants to be concerned with the degree of risk involved in situations, relationships and interactions. Some participants who identified themselves with a group of people (e.g. community members, community health staff) would anticipate not only risks to themselves, but also to that group as a whole. For instance Lyn (a staff member) indicated that nurses would anticipate risk as a group, as:

*They really have their focus and they have their networks, and they’ve got their influence, so some other younger nurse would come in and say, ‘Well, what about we form teams for doing this and look at that differently?’ They’d probably be shot down in flames quite ... strongly (Lyn, Staff Member).*

Anticipation had connotations of positive expectations, and was usually used to refer to an emotion or ‘feeling’ of realising something in advance. In contrast some managers (Jane and Tracey) and a staff member (Sue) also mentioned ‘*risk assessments*’, which were formal assessments of occupational health and safety risks involved in particular procedures. *Anticipation of Risk* was conceptualised to combine these associations of emotion with more formal procedures and implications of a quantitative risk assessment.
Anticipation of Risk was significant to participants throughout the basic social process making its impact felt throughout the process and substantive grounded theory. The significance of this core category leads to it being referred to throughout the thesis. The two properties of the core category of Anticipation of Risk, judging motive and controlling risk, provide more information on how risk was anticipated and controlled.

5.1 Judging Motive

Judging motive, a property of Anticipation of Risk, was conceptualised as participants making considered judgments of the motives of other people involved in the development of the multi-purpose service. Judgment of motive had similarities with symbolic interactionism where meaning was assigned to actions. Often participants had a long mutual history with the health service and people within their communities with whom they interacted during the development of the multi-purpose service. This history frequently led to pre-existing expectations of each other, which impacted on their interactions during the process. For example:

Some of the Health Council have got very ... set views. A lot of history relating with the previous HSM [Health Service Manager] and the VMO [Visiting Medical Officer], a big, long, political history that we don’t need here, it’s irrelevant now (Tracey, Manager).

Participants demonstrated a tendency to make assumptions about groups of people rather than individuals, often jumping to conclusions based on generalised stereotypes. This tendency toward stereotypical judgments was apparent in all phases of the basic social process. Stakeholders who lived locally were trusted to a greater extent by participants than people who lived elsewhere. Ruth, a manager who lived in another
town, was judged by the community to be an ‘outsider’ rather than a local and thereby not trustworthy. She did not feel that her knowledge was valued in this situation and struggled to convince the community that independent groups collected statistics about populations objectively:

_They had their own local knowledge ... They’d seen two or three people move back into the town, so consequently all the statistics were wrong (Ruth, Manager)._ 

When participants judged motive in relation to the multi-purpose service development, they considered three main motives: altruism, apathy and self-interest. Altruism increased _trust_ (dimension of the core category), but being motivated by apathy or self-interest was associated with _suspicion_ (the other dimension of the core category). _Suspicion_ led to the development of strategies to control perceived risks.

Participants wanted health service delivery which was altruistic. Altruism in this context implies an unselfish consideration of others. When participants judged the motives of the people and groups they interacted with, they viewed altruism positively as it resonated with their beliefs about health service delivery. Sharing this common goal or motive allowed participants to _trust_ one another and from the data it was noted that a trusted person was a less ‘risky person’. _Trust_ enabled participants to work effectively together with other stakeholders on the development of a multi-purpose service. Considering stakeholders and groups in a positive light also assisted in building _trust_ between all of those involved in the development of the multi-purpose service. When stakeholders behaved altruistically, a sense of _trust_ in and expectation of their future
support ensued. The following interview excerpts from each of the groups reveal the importance of having a trusting relationship between all stakeholders:

*Oh, yes and we’ve had support from the CWA [Country Women’s Association], Hospital Auxiliary, Lions, a fair few of them ... So yeah, the whole community, service clubs, and football clubs, you know, everyone’s behind it (George, Community Member).*

*We don’t have a problem with them because we already had a good working relationship with the staff (Mary, Manager).*

*We’ve got great confidence in them and if we have a real emergency they will stay and help us until somebody else turns up on the scene or the doctor arrives and we know them, you get to know them in a small place (Michelle, Staff Member).*

When they spoke of their role in developing the multi-purpose service, most participants portrayed themselves in a positive light during the interviews. Not only did they judge the motives of others, but they also expected to be judged in the same manner. Participants portrayed themselves as being altruistic when explaining their actions and engagement with other stakeholders, as George and Fiona did in the following examples:

*You know [local community], the town has survived so far and for how long goodness knows but while we’re there and we’re the committee, we want to try to make it the best that we can (George, Community Member).*

*I think there was a lack of appreciation to what the steering committee actually did. You know what work they put in and everything ... you know without the steering committee there wouldn’t have been anything really, I mean it might have gone ahead, but it probably wouldn’t have been as good as it is (Fiona, Manager).*

Another motive which participants described was apathy. Participants acknowledged that everyone who lived within their community was a stakeholder, but not all were
equally involved with the health service. Some people within the community had no involvement in the health service at all. Participants did not feel they could *trust* apathetic stakeholders. Participants were well aware that they resided in small communities which did not have the power to lobby which was usually associated with larger population numbers. Participants were concerned that if their community was apathetic, they would be unable to muster the support they required to convince other people of the significance of their arguments. Participant perceptions of apathy undermined the cohesion they described within the community. When apathy was perceived participants described increased feelings of isolation and feeling unsupported in their endeavours. As George demonstrates in the following quote, perceptions of apathy led some community members to feel that they lacked support when they needed it:

*We’re getting a lot more people coming in who don’t have [our local community] at heart ... And we’re not getting that sort of person in where we need that support* (George, Community Member).

When participants perceived apathy from within the local community they limited community consultation and the provision of information about the new model of health service delivery which was being implemented. For instance Dorothy described:

*the community in general weren’t terribly interested ... No.*

*Question:* No? … So did you consult with the community much?

*We had a public meeting and that was all* (Dorothy, Community Member).
According to the participants a lack of interaction with the community could cause subsequent problems. Not being provided with a great deal of information sometimes led to issues, as assumptions were made within the community which then spread in the form of rumours. When these rumours were incorrect they led to delays requiring explanations and correction. Dorothy continued to display her lack of trust for apathetic community members who created additional work:

*We’ve had to put down a lot of rumours and things because we know and we have to talk to them [community] you know and ... Explain it all, but they’re not interested in it, you know, they don’t ... ask that many questions (Dorothy, Community Member).*

Participants spoke about feeling devalued by some people in their communities. Community members work hard to achieve a better community, but reported being denied the respect they would like. Community apathy was also an issue for managers who were frequently pressured to maintain several community committees within the small communities. As Kim points out in the following quote, people who felt overworked would resign from the committee:

*There was a lot of problems with having a Health Council and an MPS Steering Committee ... they were really functioning with the bare minimum of people, because they had probably potential Health Council members on the MPS Steering Committee ... slowly but surely people if they were on both committees, they were overburdened with the amount of work and pulled out (Kim, Manager).*

A third motivation which participants perceived in people who were involved in the development of the multi-purpose service was their own self-interest. When describing this motive, participants described stakeholders who benefited from their role in the development of the multi-purpose service (e.g. increased power, financial rewards, or an
improved position). Participants were aware that resources for their small communities were limited. They feared that a poor distribution of those resources would result in a negative impact on the health of their community. Participants anticipating such risk would then take action in an attempt to control that risk.

Some staff members, such as Kate were cynical about the motives of committee members, as she thought they wanted to increase their power within their communities:

*It’s usually your most vocal community member, who usually has an agenda … So often the voice of the community isn’t very democratically heard for a start (Kate, Staff Member).*

That skill of being vocal, knowing how to attract attention and when to do so, meant that some community members had greater power than others. Kate continued to say that those community members who were not outspoken and would benefit the most from health services, were not often heard:

*It’s really hard for those people with low literacy … and low socio-economic status to even get a look in … I mean if you’re in a small town and you’re not highly educated you’re probably the one that’s going to have the most need for the MPS, because your health is going to be … poor (Kate, Staff Member).*

Self-interest was not only at the individual level, it also reflected the wider community as ‘self’. Participants were cynical about the reasons for developing multi-purpose services, believing that the government would gain financially if the cost of health care was reduced. According to participants government employees were also viewed as being self-motivated. Those employees who decreased financial spending
(demonstrating ‘good’ managerial skills) may have improved their status in the eyes of their employer. According to Kate:

*There is financial gain ... Otherwise they wouldn’t be continuing to be rolling out MPSs, they must be cost effective (Kate, Staff Member).*

When the multi-purpose service development began, differences between factions within the health service became apparent, as limited funding did not allow each faction to benefit equally. Rather than working together as a single cohesive unit, participants described divisions, as factions sought to improve their own situation. Some factions were successful, but others were not. Lyn provided an example of a faction which felt the distribution of funding had been inequitable:

*It was still just what was left with no funding left to do anything except for some fresh paint ... There were still people who had their things stored in old bathrooms and toilets. I think some things were done eventually, but it [allied health] was, certainly, really quite low priority (Lyn, Staff Member).*

In these situations participants judged other stakeholders (factions) as being motivated by self-interest. Perceiving others to be motivated by self-interest created suspicion as participants anticipated negative results for themselves and the factions with which they identified. When they were suspicious participants attempted to control the risks they anticipated.

In judging motive participants considered that people who were altruistic were generally more trustworthy and this reduced the *Anticipation of Risk*. Others considered by participants to be apathetic or motivated by their own self-interest increased the *Anticipation of Risk*. When participants trusted stakeholders, they perceived the multi-
purpose service development to proceed more quickly than when they were suspicious of their motives. In those circumstances where participants described suspicion, strategies to control risk were frequently implemented.

5.2 Controlling Risk

Controlling risk, the second property of the core category, Anticipation of Risk, describes which actions participants reported being used to mitigate the risk they anticipated. The property includes actions which participants described themselves and other stakeholders taking in the development of the multi-purpose service. As the present study was a retrospective study, participants may have viewed the strategies which were implemented to control risk in a different light than at the time they were initiated.

Controlling risk involved a variety of strategies. Only the strategies which were described in detail by participants are presented here. Participants spoke about the need to control risk in order to create trust and dispel suspicion among stakeholders. Strategies that were implemented throughout the development of the multi-purpose service included the use of expert knowledge, regulation, transparency and negotiation. Participants indicated that only some strategies were used at each multi-purpose service.

5.2.1 Expert Knowledge

The risk of not developing the new health service effectively was evident to participants. Many participants indicated that local staff (e.g. doctors, nurses) did not
have sufficient knowledge and skills to develop a multi-purpose service in isolation. For instance:

\[\textit{The medical and nursing staff ... I’m thinking they were probably the main drivers in how it was, probably didn’t have the skills to be making those decisions (Lyn, Staff Member).}\]

As a result, controlling risk often involved consulting with experts in such fields as architecture and occupational health and safety. According to participants, outside experts provided information and direction during the development of the multi-purpose service. Many experts had only a brief involvement with the multi-purpose service development which led to some experts being referred to as ‘\textit{them}’, nameless individuals who were unable to be held accountable for their advice. The following two excerpts demonstrate the inability of participants to put names to the faces or documents which provided expert guidance during the development:

\[\textit{We do have a lot of people come to our meetings like recently we had one with, she’s got a new job about health hazards and she’s doing the whole area, not just MPS and telling us what to look for and to report it and things like that (Dorothy, Community Member).}\]

\[\textit{I mean the people who are developing these codes ... I don’t know who’s on the planning committee for these things (Ruth, Manager).}\]

When experts were considered to be knowledgeable and offering something to the community, participants determined that the expert was building \textit{trust}. Ruth describes one architect whom she found very helpful:

\[\textit{I had a brilliant architect for both of them and he was just so easy to work with to the point where he said I could ring him up any time if I had a query (Ruth, Manager).}\]
Not all experts were positively viewed by participants. Experts who were perceived as attempting to take something away from the community were less likely to be considered trustworthy. Participants told how some experts attempted to frame negative concepts, such as the loss of a service, into something positive. Rather than tell the community they were losing a valued service, they would say the service was unsafe and was being removed for the protection of community members. Managers were more likely to be convinced by these arguments:

*We think also from the patient quality point of view that includes safety. So maybe there are some activities that shouldn’t be offered in a small community (Danielle, Manager).*

Community members were not easily convinced and often continued to hope that services removed by experts would one day return. The previous excerpt demonstrated Danielle’s perception that the abilities of staff in small rural health services were limited when assessed through quality indicators, but community members did not assess these abilities in the same way. The following excerpt from Peter’s interview expressed his hope:

*I would like to see obstets [obstetrics] come back in here in these little hospitals. I was born in a little hospital, not that one, the one up the town there that’s like a house. Well I made it and our kids were born in the hospitals, and now all of a sudden they’ve got to go to the big base hospitals to have their babies (Peter, Community Member).*

Participants were also not easily manipulated into thinking people were experts. Merely being invited to provide expert advice was not enough to generate *trust* among participants. When an expert’s knowledge and ability were judged by participants as
questionable, the expert was perceived to be motivated by their own self-interest, promoting their status and power. For many participants in this study expertise was perceived as being specific to limited areas or skills and not easily generalised to other areas. As multi-purpose services were still a relatively new model of health service delivery, expertise related specifically to multi-purpose services was not readily available. For example, Donna describes the situation of a dietician who was seconded to a planning position for a new multi-purpose service. Donna questioned his status as an expert, as she was unconvinced that his knowledge could be generalised to the development of the multi-purpose service:

I don’t think you can put a dietician to do that. I mean as a dietician he’s probably excellent, but to bring someone in who knows nothing of ... an actual hospital situation (Donna, Staff Member).

Participants in their own right developed a great deal of knowledge about the multi-purpose service model as it was important to them and they were actively involved in its development. This knowledge was not formally acknowledged by others as expertise. Also, multi-purpose services were fairly novel and aimed to meet unique community needs making the model not easily understood by people with little exposure to it. Expert knowledge as a strategy to control risk was undermined when ‘experts’ did not have a good understanding of, or direct experience with, multi-purpose services. As Jane points out, several people who were giving her advice were not well regarded as they did not have a clear understanding of the multi-purpose service model:

I don’t think that certain people at the area level, not the Exec because I’m fairly certain that the Exec are all plugged in, but other people at area office had no idea of what an MPS is or what it does (Jane, Manager).
Having a lack of knowledge specific to multi-purpose services may have undermined the ability of ‘experts’ (e.g. colour consultants, architects) to convince participants of their ‘expert’ status. When these external ‘experts’ were engaged to control risks they had difficulty establishing trust. Frequently teams of ‘experts’ were engaged by government departments and introduced to participants as having previously designed a variety of similar facilities. Experts’ interpretation of what was required did not always match that of participants’, such as in this example about suction equipment:

_We wanted a little sucker on the wall … I went out there and said, ‘What in the blazes is that?’ They said, ‘That’s your sucker.’ I said, ‘What am I sucking?’ He said, ‘Lots by the look of it.’ [Laughs] I think I can suck the dam out with that. It’s massive, apparently its equivalent to something they’ve got in Royal North Shore … they said, ‘But we thought that’s what you wanted.’ ‘No.’ I said, ‘You didn’t talk to me about this. I wanted a little wall sucker’ (Manager)._

Instead participants preferred those experts whose opinions were more congruent with local opinion and were able to create tangible results. Experts who sought the opinions of participants, and produced enhanced service provision were highly spoken of:

_She was very good and she put a lot of ideas forward and then we had a plan and then she also came back and pulled the plan to pieces and said it was no good and we need this, this and this … I think we’ve got to thank her, a lot (George, Community Member)._

When experts were perceived by participants to impose their ideas upon the project and produced subjective outcomes, they were not appreciated. In the previous example a plan was constructed and although the ‘expert’ ‘pulled it to bits’ the result was objective

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1 Burns and Grove (2007) point out that in qualitative research, limited participants and extensive use of quotes can lead to breaches of confidentiality. As the quote could identify a specific multi-purpose service, and a multi-purpose service would only have one manager, a pseudonym is not provided in this situation.
– in that more services were requested. In the following example, the result was more subjective; the consultant dictated the colour scheme and this, quite naturally, provoked a range of subjective responses from people during the development of this particular multi-purpose service. George stated:

_We were dictated to by the colour consultant ... they put the whole thing together and came back with these purple posts. I think they looked disgusting_ (George, Community Member).

In the above two examples participants reported that experts were forcing their opinions on them – the first offered them options which were seen by participants as being real and worthwhile. The second example, where only one option was suggested by the expert (a colour), was seen by participants as being of questionable value.

Participants were willing to _trust_ some experts, but they preferred their own local sources, and were often suspicious when local experts were disregarded. The following three excerpts demonstrate the lack of trust in experts external to the local community:

_The chap that was in charge of the dos and don’ts ... made one big boo-boo. Which was I told him that the natural gas line was coming through [local community] and that we should prepare to put everything on gas that we could. ‘It’s not coming through [local community]’ he said, ‘it never will.’ ... It’s through there now ... I’d even told him where I got the information. He said, ‘Well I’ve got it from somewhere else’_ (Peter, Community Member).

_They would only look at our LGA [Local Government Area], they looked at [local community] LGA [strikes desk for emphasis] and they said, ‘This is how many people you’ve got blah, blah, blah,’ but ... our outpatients, and the doctor on at that particular time had two thousand people on his books, and most of them weren’t from [local community] ... [They] did not want to know_ (Jane, Manager).

_The architect pretty well did his own thing. It isn’t designed by a nurse ... at all, the rooms like the hostel and nursing home rooms especially are the worst, the only way we can put their bed ... because its all windows, is facing one area, then_
when you get them out of bed and get them, take them into the bathroom the door pulls forward, towards the bed so you have to walk them past the bathroom, open the door out of the way, move, get them to come backwards or turn around and then put them in (Sue, Staff Member).

In Jane’s situation the experts from the Commonwealth had the power to progress the project and it went ahead despite her misgivings about their statistics. Jane states these experts ‘did not want to know’ – she judged them as being apathetic and her suspicion increased in this early phase where the need for services was being determined. Experts may not have been well respected by participants, but they were respected by the decision makers (Department of Health, who usually employed them) and were able to propel the project forward even when they were not trusted:

*You were working with architects anyway and you don’t have a lot of say. They usually have the final say anyway* (Helen, Manager).

The hiring of external experts by the Department of Health seemed to create a barrier between the participants (local level) and the decision makers (government departmental level) in the development of the multi-purpose service. Bringing experts into the development was designed to reassure stakeholders that decisions were well considered and carefully judged by people who were competent in their fields. It aimed to build *trust* with stakeholders and to dispel their *suspicion* while the development progressed.

### 5.2.2 Regulation

Participants described documented rules and regulations as providing consistency during the development. For participants documentation was a strategy designed to
ensure equity. Documentation gave an appearance of formality and stability which other strategies for controlling risk did not have. However, once something was written into a document it became difficult for stakeholders (including the participants) to change (adjust or remove). Documentation by government departments also gave the impression that regulations were imposed by a legitimate body. Further legitimisation occurred through longstanding usage which indicated that regulations were reasonable and effective as they had been implemented for some period of time. The strategy of documenting regulations was often effective. However, this strategy could backfire if regulations were seen to change too frequently, as the strength of this strategy lay in its stability.

Documentation of what was occurring elsewhere allowed participants to control the risk of inequitable distribution of limited resources – the participant could then argue more effectively for what was ‘normal’. Participants who were managers involved in area-wide roles found regulations to be beneficial, allowing them to limit unreasonable expenditure at each location and argue with funding bodies for increased expenditure when funding was limited. For instance Danielle, a manager, stated that:

*Sometimes it’s really good to be able to go back to the guidelines and say look this has been really considered and the recommendation is so many square metres for a disabled toilet. I mean it just makes life a lot easier and these are the layout possibilities for a disabled toilet, so I mean it just makes planning a lot easier and design a lot easier (Danielle, Manager).*

Participants who were local health service managers were more directly affected by the implications of these regulations, and were not as likely to trust them as those participants who held area-wide managerial positions. The roles of health service
managers included some clinical work within the new facility and dealing with complaints from staff members. As Ruth points out, regulations need input from the people who are most affected by them:

_I mean the people who are developing these codes should actually get out here and see … or go to a place where lifters and things are being used … To judge for themselves, you know what is ample room and what is not … but I’m sure that it’s not a female nurse, who would know. Yeah, see, the users have got to be involved (Ruth, Manager)._

For the hostel, where Helen worked, the changes associated with the development of the multi-purpose service had been compounded by another change as the area health service had restructured:

_That’s one thing I don’t like … it seems to change all the time … these policy directives … we had them all for [old area health service], and now we have them for [new area health service] (Helen, Manager)._

Regulations were a strategy implemented by government departments and the area health service to control the risk of allocating too much funding to any one health service; they ranged from being extremely specific such as documenting how large rooms should be, to the broader, overarching regulations such as the variety of health services which should be provided. Regulations were used in an attempt to reassure participants that every location was being treated equitably and in the same way as other communities. Participants believed that regulation was designed to control the risk of being seen to favour one community or one group over another.
5.2.3 **Transparency**

A third strategy which participants described to control risk was transparency. Transparency involved an accurate and timely provision of information about how decisions were made and how much progress was being achieved. Participants described the degree to which such transparency took place as varying at each location. When some managers, who were participants in the study, anticipated risk, they were suspicious that a lack of knowledge about the health service would lead other stakeholders to misconstrue their motives. Rather than be seen as behaving in a secretive manner, they attempted to provide information about the development of the new multi-purpose service. Participants identified that managers who implemented the strategy of transparency would have ‘open’ (Bev, Staff Member) meetings where anyone was encouraged to attend and participate in the development of the multi-purpose service.

Bev, a staff member, had a discernibly more positive experience of multi-purpose service development than that of other participants. She describes a multi-purpose service where staff input was obviously valued and taken into account to make modifications to plans and provide direction:

*They involved the staff from the very beginning in the planning. So we had progressive draft plans on the board and we could have some input, and I must say that a lot of it was listened to ... there wasn’t enough cupboard space for storage and they fixed that up and they also had the patients’ sitting area right near the sister’s station, which we felt would be very difficult to maintain confidentiality because visitors [could be] listening ... so they moved that (Bev, Staff Member).*
Participants at other sites did not always have similar experiences. Several spoke of having decisions ‘imposed’ upon them and a lack of transparency, as in this example provided by Kate, who stated that:

> It was ... imposed upon us ... we really ran out of space, like they did the acute, and we had allocated space for primary health care, and then when the reality came there wasn’t enough, and then the doctor moved in. Well that was just done. I just went one month and it was there, the doctor’s surgery was there (Kate, Staff Member).

Participants were aware that both the Commonwealth and State Governments documented the importance of consultation with stakeholders, and delegated this role to the health service to manage. However, participants believed that was endangered when managers weren’t provided with accurate information. In such cases participants described attempts to use the strategy of transparency which resulted in inaccurate information being announced to stakeholders with undesirable results. Major features of transparency included accuracy and timeliness of information. Trust deteriorated when information was inaccurate and timelines were not met. In the following quote, Kate describes the reaction from other staff members as their trust deteriorated:

> I can remember coming in and feeling tension about, ‘Oh, this is not finished yet. When is it going to be finished? They said it would be done and it hasn’t been done. This equipment hasn’t arrived.’ It wasn’t easy (Kate, Staff Member).

Transparency was also difficult to maintain in the face of contradictory information or a lack of information. Jane, a manager, describes some difficulties which she encountered when trying to get information from government departments:
The Federal Government just ... didn’t want to know about aged care basically. They wanted to place it in the State’s hands and then at the office and in the media, ‘That is the State Government’s responsibility. We’re supplying that funding to the States, so it’s the State Government’s responsibility’. So I think that it’s a lot of politics that needs to be resolved at a higher level ... but here down on the ground they don’t realise the implications of some of their decisions (Jane, Manager).

The aim of transparency was perceived by participants to be a strategy to control risk by providing information to stakeholders, to build their trust in the development. The difficulties which Jane describes of obtaining information related to government responsibilities, undermined these attempts at transparency. Instead of building trust the lack of transparency created suspicion as participants perceived government departments to be avoiding responsibility. Michelle likened it to a dangerous game:

*There’s a lot of cat and mouse goes on with the funding (Michelle, Staff Member).*

Participants identified that transparency was not a strategy used by all managers; some implemented other strategies instead. Those participants who were managers and did attempt to use transparency described their aim to address issues early, in the hope of generating an optimum result. Transparency attempted to ensure that stakeholders were aware of progress as it occurred. Transparency would provide stakeholders with sufficient time to intervene if they did not have confidence in the decisions being made. The strategy of transparency reduced the risk of stakeholders claiming that their input had not been acknowledged when the development was complete. It did, however, add to the workload of managers (particularly when confronted with apathy among stakeholders) and in some cases caused significant delays, when stakeholders were
unhappy with progress. In this example, Ruth describes the demands of a doctor who wanted an additional room:

*Especially with the doctor wanting a second consulting room. There was lots of meetings held over that and everything got held up because it meant structural changes and we were probably at the stage where we had the framework up (Ruth, Manager).*

Transparency was a strategy which was mainly implemented by participants who were managers or community members. Both groups of participants attempted to keep communities and staff members informed (frequently through meetings) of the progress which was occurring. Another strategy which was used by participants to control risk was negotiation.

### 5.2.4 Negotiation

Negotiation was the final strategy described by participants to control risk but it was used infrequently. In order for negotiation to result in mutual agreement, it was necessary to find ‘win-win solutions’ with other people involved in the development of the multi-purpose service. Many participants perceived this strategy to have two stages: the first, when their opinions were sought; and the second, when solutions were negotiated with them. Although each of these two stages built *trust*, the first stage also built an expectation that the second would follow but if negotiation did not occur, participants became angry.
Tracey described a scenario where some consultation with staff members took place. Staff members were asked to provide ‘wish lists’ and reports detailing what they needed, but then decisions were made without their involvement:

*They did get asked for a wish list but not a lot of stuff on their wish list was ordered (Tracey, Manager).*

Kate who had been involved in the development of three multi-purpose services described similar scenarios but contrasts this to her previous experiences, where negotiation had taken place. In negotiation, Kate had been active in decision making, which had given her the power to decide what she would prefer to give up to obtain the benefits she felt were important to her and her clients:

*We were always asked what do we want, with regards to equipment and room and location, but often [in developing multi-purpose services] that didn’t evolve. We’d have a wish list, but not always did that wish list come into existence ... [my previous experience was] when you’re negotiating a space often it’s not the perfect clinical environment, but a room might not have a sink or a toilet as an ensuite, but it will have a nice waiting area, or a nice window with light in it (Kate, Staff Member).*

When negotiation took place, participants described discussions in which alternatives, constraints and the opinions of other stakeholders were taken into account:

*Obviously there is a little bit of negotiation that happens there but it depends on the needs and every project is different, like [community] they already had a large day care room. It really is quite large so there was an agreement in the new facility even though it went way over the guidelines because the community had paid for that – that room in the old facility, but we built in something of the same size. So there is that sort of negotiation that happens there but ... we don’t want to build really, really large GP rooms because that will just mean we’ve got to cut space somewhere else (Danielle, Manager).*
Negotiation as a strategy to control risk frequently failed due to the limited ability of managers to implement the strategy effectively. Managers described having a lack of information and time which negotiation required.

*Anticipation of Risk* was a complex category and consisted of two properties, judging motive and controlling risk. *Anticipation of Risk* also ranged along a continuum (i.e. dimension) with *trust* and *suspicion* at each end (see Figure 4). Participants described situations and experiences which were at either end of the trust/suspicion continuum but neither one or the other seemed more prevalent in the findings. For this reason both *trust* and *suspicion* were viewed as contributing to balancing the risk associated with the development of multi-purpose services.

**Figure 4: Anticipation of Risk**

![Image of a diagram showing the relationship between judging motive, controlling risk, trust, suspicion, and anticipation of risk.](image-url)
5.3 Trust

Trust was a dimension of the core category of Anticipation of Risk (see Figure 4); it was one end of a continuum. Participants described trust as involving a confidence in and ability to rely on other people involved in the development of the multi-purpose service, to behave consistently in a benevolent manner. In this study, collective action on the part of participants was essential in addressing community health care needs. When trust underpinned such collective action, the multi-purpose service development occurred at a faster pace. When participants judged the motivation of other stakeholders involved in the development to be altruistic, they were more likely to trust each other and less likely to implement strategies for controlling risk. In this way trust reduced workload and improved communication as participants did not require reassurance or convincing that decision making would be undertaken in their best interests.

Trust mediated the perception of risk, limiting a participant’s need to control risk. Participants who were trusting of others did not interfere with the process of developing the multi-purpose service. They accepted not only that it should go ahead, but also that the development would be effective and they would have a better health service when it was completed. As Michelle points out, this sentiment was frequently shared by the community:

*We just all … and the community just thought, well there’s certain guidelines that just have to be met, and they’ll be met. So it will be safe … A lot of trust in all that. That it would be done and done properly (Michelle, Staff Member).*
The benefits of trust were widely acknowledged by participants. Some participants believed that they needed to trust a committee rather than everyone having input, as this would not be feasible:

"You trust and maybe it’s probably a good thing, you can’t have too many people, everyone would have a better idea, and I suppose they just follow a guideline (Michelle, Staff Member)."

More general benefits of trust included the security which participants felt in their community. Despite not explicitly mentioning social capital, the concept was apparent in their conversation where rural communities were acknowledged as having greater trust in community members than was found in cities. Jane, a manager, describes these features as part of the ‘tree change’ which is attracting people into her small community:

"I know a lot of people who have moved here have brought their parents from other places here because they can get services and its quiet and its, you know, we don’t have law and order problems and things like that (Jane, Manager)."

Other participant groups such as Jenny, a staff member, agreed that their community had social capital, which was indicated by people not wanting to leave the community to obtain health services:

"People are demonstrating that they want to stay in their home town. They don’t want to leave ... home (Jenny, Staff Member)."

Peter, a community member, also described social capital when he mentioned the debt which was owed to people who had built their community:
The backbone of our country, the foundation members, I think they should be able to be looked after right up till their time (Peter, Community Member).

When trust was exhibited, committees presented a united front, solving dilemmas with collective action more readily than if they were suspicious of each other’s motives. In the following excerpt Danielle describes the benefits of a committee where members trust one another:

*It was actually a strength because we were over budget at one stage and we had to come up with solutions and everyone from those different camps putting their heads together, we were able to respond to the department really quickly (Danielle, Manager).*

Trust was created when altruism was judged to be the motive of other stakeholders involved in the development of the multi-purpose service and when participants perceived services to be equitably distributed. Perceptions of equity added a sense of security to altruism, a belief that services were reliable and available for all those who needed them, rather than just the elite:

*A lot of them [community members] think it would never be hard to get in there [high-level aged care] because I’m so and so, but ... It’s not who you are, but a lot of them think it is, it’s not (Peter, Community Member).*

Participants determined to what degree they would trust others; but trust was not assigned easily or permanently. The benefits of trust could be short lived when participants felt that their expectations were not met. As trust and suspicion were at either ends of the same continuum, broken trust frequently led to some degree of suspicion. Despite trust having positive connotations, too much trust, or trusting people
who did not live up to expectations, resulted in an imbalance which was negative (see Figure 5).

One manager described how her trust in the development of the multi-purpose service had been displaced:

*I just thought, ‘Oh, yeah, they’re going to renovate. We’re going to have a few more beds,’ and that was it, but you think about the acute end, everything changed from what it originally was going to be. I mean we lost beds* (Fiona, Manager).

In this situation, Fiona’s original trust in the development of the multi-purpose service was broken. Although she claimed this breaking of trust was not the sole reason for her leaving, Fiona was one manager who left the health service to work elsewhere within her small community. Community members expressed similar feelings, justifying a lack of trust through a history of broken promises:
There was a huge lack of trust, they [local community] didn’t trust the government, they didn’t trust the health service and in a lot of cases rightly so because they tell you one thing and do something else (Christine, Community Member).

Although trust would appear to be mainly beneficial, it could have its drawbacks. Too much trust led to the acceptance of situations that were less than ideal. As Helen points out, she should have been less trusting and the outcome may have been improved:

Probably in hindsight ... I would have done it differently ... a lot of things, yeah. Probably would have actually put our necks on the line and said, 'No we need to have the hostel on site.' That would have been one of the first things (Helen, Manager).

Trust was generally viewed as being more positive than suspicion, but too much trust also created problems. When stakeholders were trusted their opinions were accepted without question or discussion. Trust could lead to situations where alternative opinions and plausible solutions were overlooked. A lack of questioning and discussion as arose in these situations of trust increased the speed at which the development of the multi-purpose service occurred. This speed limited the ability to identify problems early enough to allow intervention.

5.4 Suspicion

Some participants spoke of a lack of trust or a belief that another person or group may act in a malevolent manner towards them. This data was conceptualised as suspicion, the other end of the continuum which made up the dimension of Anticipation of Risk. Participants described suspicion not only from their perspective, but also from the perspective of other stakeholders involved in the development. Most participants
described a balance of trust and suspicion, where both existed in reasonable amounts. For those situations where too much suspicion was described, an imbalance was created which led to delays in the development of the multi-purpose service (see Figure 6). As described earlier in this chapter (see Judging Motive, Section 5.1), judging other people involved in the development as being motivated by apathy or self-interest was likely to heighten suspicion among participants.

Participants described some stakeholders as being suspicious of the potential outcomes of their interactions with others involved in the development of the multi-purpose service. These suspicious stakeholders were perceived to be resistant to the ideas and perspectives of others. The suspicion would need to be addressed in order for the development to be progressed. Suspicion lengthened the process of developing the multi-purpose service, but allowed divergent perspectives to be heard. The strategies
previously explained in the property of controlling risk (i.e. expert knowledge, regulation, transparency and negotiation) were described as being implemented to reduce suspicion among stakeholders.

Suspicion was described by participants in relation to the risk associated with possible loss of services, employment or status. Suspicion could also be created when stakeholders involved in the development of the multi-purpose service made threats or broke promises. One participant describes how, in an initial town meeting, some community members expressed their suspicion that the development would not go ahead:

*We had preliminary plans and we had about a 120 people there, but a lot of them were negative. Saying we’d never get the money, we’d never do this, we’d never do that* (George, Community Member).

Such suspicion did not halt the progress of multi-purpose service development in this community and George was quite proud that he had proven these community members wrong. Other participants told of locations where multi-purpose services had not gone ahead or had been delayed; in these locations such suspicion would have been justified. Several participants also described community suspicions that their health services would be reduced. For instance, Barbara stated:

*They were worried they were going to lose their hospital* (Barbara, Staff Member).

Similarly staff members also feared losing the hospital or its services and the impact this would have on the health of their community:
I thought that maybe we wouldn’t have enough acute beds to offer to people in the town (Jean, Staff Member).

Both Barbara and Jean described an overall decrease in acute care beds at the locations where they worked, justifying their suspicions. Despite its negative connotations, this degree of suspicion allowed participants to rally support which could assist them in lobbying to maintain their services.

Unlike community members, participants who were staff members and managers relied directly on the existing health service for their livelihood. Many staff members were convinced the reason for the development of the multi-purpose service was a reduction in expenditure, and several managers cited improved cost effectiveness as a documented aim of developing multi-purpose services. Managers who controlled local budgets described the greatest expense in the health care industry as being staff costs, and staff members were also frequently aware of this, so they felt justified in their suspicions that their jobs were at risk.

In addition, many staff members employed by existing aged care services were described as having few or no formal qualifications. These staff members were aware that a lack of qualifications had previously precluded them from being employed at the hospital, and added to their suspicions of possible job loss when they believed the hospital would take over the aged care service. For these staff members the fear of losing their employment was prevalent:

We had two RNs and they were cutting us back to one and that was it and that was why it [becoming a multi-purpose service] was happening (Donna, Staff Member).
Even community members were concerned about staff losing their jobs, and George commented that:

_They thought they were going to lose their jobs ... Yeah, it took two years to get them over that_ (George, Community Member).

Even managers were not immune to _suspicion_ when they saw their responsibilities dwindling as acute care services were threatened; they justified this _suspicion_ by describing locations where a single manager was responsible for more than one small health service. Jane indicated that managers in small rural health services were concerned about their employment, particularly when the area health services were restructured:

_The other thing too, is the fact that because we went from [old area health service] into [new area health service]. That has been a lot of changes too, so a lot of bang, bang, bang [claps hands at each ‘bang’] changes ... We’re looking down the gun because of the fact that in [new area health service] they’ve put on so many layers of management over us ... People are paranoid and petrified that they’re going to lose their jobs ... they really are_ (Jane, Manager).

The participants who were staff members in this study were not a homogenous group. Those who worked in existing hospitals were perceived as having a higher status partially due to the acute nature of their work as well as their ability to specialise; whereas those working in existing community and aged care services were perceived as having a lower status as they required a more general knowledge base. Several staff members who had been employed in the pre-existing hospital perceived a loss in status when it became a ‘multi-purpose service’. Some staff members indicated this loss in status would be sufficient to cause their resignation:
There were a few of them that were going to pack it in and ‘That’s it, we’re retiring, if I’ve got to go over there. I didn’t want to work in a nursing home. I’m not working there’ (Ruth, Manager).

Despite this threat participants described that not many staff members left when the development took place. Tracey indicates that retention of staff may have been due to a lack of choice in these small communities where the health service was a major employer:

_Probably a lot of the staff would have left had they other places to go but ... They live in, and [have] families and husbands on properties or have jobs in town [which] meant they stayed_ (Tracey, Manager).

Participants frequently focused on aged care as an important feature in the new multi-purpose services. There was a widespread perception that education and staffing requirements were lower for aged care services than for acute care services, which were previously core business for the health service. This _suspicion_ had frequently been reinforced in the communities where these participants worked, when aged care services employed unqualified staff. This perception added to the _suspicion_ that status would be lowered among staff members:

_There’s an assumption that you don’t need to have education to look after older people, like you just do it but in fact to do it appropriately and effectively and in a caring environment which is their home, you’ve got to change your attitude a lot_ (Kim, Manager).

_Because you’ve got aged care, because it is [emphasis provided] aged care, you get your staff reduced_ (Donna, Staff Member).

_I think for a lot of registered nurses the idea of the MPS was quite scary because we see that as a numbing down or dumbing down of the skills that they once had_ (Kate, Staff Member).
For the participants in this study, suspicion sometimes led to feelings of anger as they felt that the change from existing services (either a hospital or aged care facility) to a multi-purpose service was imposed upon them and they had been forced to participate. In order to develop the multi-purpose service, some participants felt that it had been necessary to convince pre-existing organisations (Health and Aged Care (HACC) local hostels, community transport) to merge with the existing hospital. Sometimes the merger led to the creation of suspicion as government officials painted a grim picture of the future were they to remain independent, pushing organisations that were previously community managed to accept the multi-purpose service model. For instance Jane, a manager, said:

*The board that used to run it [hostel], were obviously just local community people and basically, I think they just had a gun held at their heads from the Commonwealth Government, saying, ‘You know, you’re just a ten bed hostel, you’re not financially viable. There’s no way that we can see ourselves funding you. If you don’t go MPS, you’re not going to get our Commonwealth funding’* (Jane, Manager).

Participants described these organisations as being led to believe their salvation lay in accepting the new model of health service delivery; otherwise their suspicions that health services would be reduced would become reality. Christine, a community member, who was involved in a pre-existing, community-managed hostel, described their efforts to improve its viability, but perceived that they had little choice but to accept the new model of health service delivery:

*We even spent about forty thousand on the hostel getting a pan room and a proper autoclave and all that sort of stuff. Trying to work out how we could stay independent, but then realised that that wasn’t going to happen because we’d lose*
our hospital. So in a way it was political blackmail (Christine, Community Member).

Being given such a limited choice was viewed by participants as a threat, which served to create suspicion and bind them more closely together as they felt they had shared a common experience of adversity with opposition from mainstream society. For most participants in this study, the focus on costs and economic benefits was a major cause of the suspicion associated with the risk of establishing a multi-purpose service. Suspicion destroyed trust, leading to the belief that decision making was based on economic benefits rather than in the best interests of the community.

When suspicion was too great, it created problems, particularly delays. However, some suspicion was justified and it led to open discussions, which identified solutions and additional funding, leading to an improved health service. As part of the core category of Anticipation of Risk, trust and suspicion are apparent throughout the basic social process which emerged from the data. All participants judged the motives of other stakeholders who were involved in the development of the multi-purpose service and acted to control the risks they anticipated.

5.5 Summary

The data revealed a core category which was conceptualised as Anticipation of Risk which had two properties, judging motive and controlling risk. Participants involved in the study judged the motives of other people who were involved in the development of the multi-purpose service. Participants liked to portray themselves as altruistic and were more likely to trust other stakeholders whom they also perceived as being altruistic.
When participants perceived other stakeholders as being motivated by their own interests or being apathetic, participants anticipated greater risk and were suspicious of the outcomes.

When participants anticipated greater risks, they developed strategies to control those risks. Some examples of the strategies which they used have been described, including expert knowledge, regulation, transparency and negotiation. Some strategies were successful, but many participants indicated a degree of suspicion that they were being manipulated which could have led to the failure of some of these strategies.

Not only does the core category of Anticipation of Risk describe the majority of change which took place in the basic social process which emerged from the data but it also links the phases together. The three phases (driving change, engaging with stakeholders and collaborating) and their relationship with each other will be described in the following chapter, with examples of data generated from participants which illustrates the complexity of each phase.
CHAPTER 6. THE BASIC SOCIAL PROCESS

The previous chapter described the core category, *Anticipation of Risk*. This description included the two properties of judging motive and controlling risk together with the two dimensions of *trust* and *suspicion*. The core category *Anticipation of Risk* was of concern to all participants and impacted on the substantive grounded theory which emerged from the data.

In addition to the core category, *Anticipation of Risk*, the data revealed a basic social process which was called ‘Developing a Collaborative Rural Health Service Identity’. This process consisted of three phases: *driving change, engaging with stakeholders* and *collaborating*. The core category of *Anticipation of Risk* also impacted on each phase of the basic social process and provided the link between each of the phases. Participants in the study continued to judge the motives of other stakeholders and to implement strategies to control the risks they anticipated in all three phases. The dimensions of *trust* and *suspicion* continued to impact on how participants reacted in each phase. This chapter will describe each phase and will detail their properties in greater depth with examples from the data. The impact of the core category on each phase will also be presented.

6.1 Driving Change

The initial phase of the basic social process of ‘Developing a Collaborative Rural Health Service Identity’ was *driving change*. Participants believed that the momentum to develop a multi-purpose service came from a variety of sources. This phase described
how the process began for the participants involved in this study and the issues which were of concern to participants early in the process. *Driving change* consisted of three interrelated properties: recognising the need for services, economic issues and ownership (see Table 8). The relationship between recognising the need for services and economic issues was clear to participants who were aware that services required funding. They expected that the ‘owners’ of the health service would organise not only the services, but also the funding, so felt a degree of ownership when they contributed to the funding or to attracting the funding. Each of these properties will now be discussed in detail with illustrations from the data. Discussion of the phase will be concluded with a discussion of the impact of the core category on *driving change*.

**Table 8: Properties and Dimensions of Driving Change**

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<th>Driving change</th>
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6.1.1 Recognising the Need for Services

The first property of the phase *driving change* was conceptualised as recognising the need for services. This property was described by participants as involving an evaluation of the need for both pre-existing and prospective health services. In some multi-purpose services recognising the need for services involved decreasing pre-existing services and the identification of a need for additional services.
Identification of the need for prospective health services varied from a vague recognition of ‘more services’ (Dorothy, Community Member) to specific staffing requirements. Participants who were managers were most specific and were perceived as having greater access to relevant data. For instance one manager described the situation that she had encountered:

_A community might want x number of acute care places and the Area [Health Service] might think, ‘Well there’s no data to demonstrate that you will need x number of acute care places’ (Danielle, Manager)._}

In some cases participants described methods which had been used to ‘improve’ statistics. They indicated these types of behaviours were related to motives of self-interest and created distrust among participants. In the following example, Jane described a doctor who admitted more patients than usual:

_When we knew that we were planning for the MPS, our occupancy rate shot from 47% up to about 89% [thumps table for emphasis] in an entire year ... and what [doctor’s] reasoning behind that was, to say that we needed our hospital beds ... he wanted to make it bigger and unfortunately he shot himself in the foot, because it just stood out so glaringly (Jane, Manager)._}

In common with the participants in this study, this doctor (as described by Jane) appeared to anticipate a risk to the number of acute care beds that would be available in the multi-purpose service. His strategy to control that risk was perceived by participants to be for his own interests, and led them to question his motives. This example also demonstrates the impact of the core category and its properties, such as judging motive, on the phase of _driving change._
Recognition of the need for further funding for their health services led some participants to embrace the multi-purpose service concept and drive its development. In the following instance a manager described a local council which drove the initial planning phase, advertising for and selecting the Multi-purpose Service Steering Committee members without much input from the health service:

The Council decided that they would drive the process, which was strange to me, but they took carriage of it and they advertised in the local paper for committee members to be on the MPS Steering Committee ... we didn’t have a great deal of input into that process (Kim, Manager).

Some community members were successful in driving these efforts to create change; others’ attempts were not well supported. Participants portrayed some community members who received limited support from others as being motivated by their own self-interests rather than altruism, and they were accused of making unreasonable requests. In this example a manager describes that:

He was one person, he just had an agenda; he had his little wheelbarrow and that’s what he was going to do ... Number one, it would be very nice to have a hydrotherapy pool, but a bit unnecessary. Number two, who’s going to run it? Number three, who’s going to maintain it? And number four, we didn’t have the allied health personnel anyway, to be able to use a hydrotherapy pool, but I couldn’t get it through to this gentleman (Manager).²

As the above example indicates, participants assessed the need for services differently and this sometimes led to disagreements. When disagreements occurred locally, access to stakeholders enabled discussion to occur. Being local assisted in resolving issues, but

² The unusual nature of this request may make the multi-purpose service recognisable, and, as a multi-purpose service usually only has one manager, a pseudonym for this participant is not supplied.
when disagreements occurred with people from outside the community, participants found it more difficult to discuss issues and often attempted to lobby politicians or attract media attention to get the resolution they desired. Danielle provides an example of a situation she was involved in:

*The ambulance had decided to take the ambulance service out of that town [and] put it in a more central town. From a planning point of view, it made a lot of really good sense. They [local community] complained and it’s easy to complain, you simply write to the Minister and it creates a lot of action and they won (Danielle, Manager).*

One service which the majority of participants agreed was needed in their communities was aged care. They particularly felt that the elderly should be able to age comfortably within their own community. The following three excerpts reveal similar concerns raised by participants who were from three different communities:

*I wouldn’t hesitate in going into the hostel, and then going up the ladder, because it’s there and I know it’s good. It’s still home, you’re still in your own town. Yeah That’s it and also you’re sitting there with Bill Jones, Tom Smith. You’ve known them for years, but you go to these places away, well you might be sitting there near an office worker and you’re a farmer; got nothing in common whatsoever … no that’s where we gain in having it in the country (Peter, Community Member).*

*From a resident point of view certainly the quality of life hopefully is better, with more appropriate accommodation than what it was like in [community]. Those poor old things in the four bedded wards and no privacy and nothing really from home. It wasn’t very conducive for ageing in place that’s for sure (Kim, Manager).*

*Ageing is increasing and placement numbers are therefore increasing and people are demonstrating that they want to stay in their home town. They don’t want to [clears throat] leave … home and often that’s a big issue for people resisting going into care if it means leaving their home town for them and for their family because often then that creates a problem with them being able to be visited, because often, if one person goes into care the other spouse might have issues with transport (Jenny, Staff Member).*
Many participants involved in this study had different views about the services which were required, but in order to begin the phase of \textit{driving change} some recognition of a need for a change in service provision was required in order to begin the development of the multi-purpose service. Participants indicated that together local and external stakeholders negotiated each community’s need for services and the economic issues to which they related.

\subsection*{6.1.2 Economic Issues}

Economic issues were a significant property of the phase \textit{driving change}. The property was conceptualised to include issues of community sustainability as well as the sustainability of the health service. This property frequently required participants to trust those external drivers of change who had control of much greater amounts of funding than the local community could access. According to participants the control of funding constituted decision making power.

The multi-purpose service model of health service delivery was designed for small communities. Participants in this study assumed that a small-sized community had little power in comparison to larger cities. This assumption led to a lack of trust when dealing with government departments and a general suspicion that rather than increasing health services in a small community the government would prefer to reduce their services. For instance Jane stated that:

\textit{I think they [local community] just see it [multi-purpose service] as a cost-cutting measure, I think they see it as a stop gap (Jane, Manager).}
Participants also described the health service as a major employer in these small communities. The strong link with employment meant that economic repercussions for the entire community could result from changes in health service delivery. Although participants (managers and staff) in this study maintained their employment, some felt guilty as they recognised the impact of unemployment on their colleagues. As Barbara indicates, some staff had been ‘lucky’ but others were not:

It was over twelve months ... there was no work ... I was lucky I was over there and I was just transferred straight over ... most of them were farmers’ wives ... those poor devils, I mean that was their money coming in for kids at school and whatever, so I’ve found that was a little bit hard, that was harsh (Barbara, Staff Member).

Not only did participants perceive cost cutting as a driving force for the development of the multi-purpose service, but several indicated that cost shifting from the State Government to the Commonwealth Government was also significant. As Bev points out in the following quote, elderly patients had been occupying State-funded acute care beds in the pre-existing hospital which would become Commonwealth-funded aged care beds in the new multi-purpose service:

Obviously they are getting the Commonwealth funding for the long stay beds which has to be assistance, so I can see it being a push politically from the State ... if an MPS wasn’t there before then those old people would have had to be. They were occupying bed days ... so they were costing someone (Bev, Staff Member).

The need for the State Government to attract more funding was obvious to participants, who described neglected health service infrastructure. Participants described existing health service buildings as being ‘run down’ (Danielle, Kim, Margaret, Managers; Lyn,
Staff Member). Neglected health care facilities led participants to distrust the area health service that had allowed this to occur and the government (many participants did not distinguish between the two levels of government) that they felt had created the situation. The condition of many buildings was obvious to everyone and impacted on the services being provided:

*It’s a hospital that’s got the roof falling in and termites eating around the doors, and the doors falling off* (Kate, Staff Member).

The dilapidated state of buildings made it evident to participants that additional funding was required by their health service and that it would be unreasonable to refuse an offer of a large amount of money. Participants frequently felt that the situation of neglected facilities had been created by the government. The neglected and ‘run down’ nature of the facilities reduced their trust in the government and its departments. This trust was not improved when they felt they had been forced into accepting the new model of health service delivery as the only option to upgrade their facilities. All participants recognised the need for investment in their health service, but no participant was able to identify another option for attracting funding other than from the State Government. Sonia revealed:

*I think that was the only way we were going to get the funding and everything from what I can understand* (Sonia, Staff Member).

The lack of financial control left some participants feeling vulnerable in a situation where they had little power during negotiations. These participants found it easy to attribute the government motives to self-interest in attaining economies of scale through
adopting the new multi-purpose service model. This perception of the government being motivated by self-interest resulted in participants being suspicious, stating they felt that they were being blackmailed into accepting a multi-purpose service. Participants described having little choice but to be grateful for what was offered to them:

*Without it we would have nothing, so really there is no negative, is there? (Christine, Community Member).*

*It was more to do with funding, and I mean that’s not going to change. Is it? You know, I mean its not a pot of gold. There’s got to be some restriction on how much they spend and everything, so, yeah so I’m probably being very unrealistic thinking that anything could be better than what it was anyway (Fiona, Manager).*

When participants accepted the multi-purpose service model of health service delivery, they perceived their degree of success to be based on the amount of funding they managed to attract. Tracey commented that:

*How else were they going to get five million dollars spent on it? ... several business people in there that have a lot of clues, how to be persistent and harass, bordering on harassing government agencies ... He is passionate, he’s got a [local] company, so he’s a very astute businessman and he’s been in it since the word go ... And he’s so proud of it, he’s so happy that it’s come to fruition and he should be proud of it (Tracey, Manager).*

Unlike government departments, local participants in this study took a long-term view and a wider focus of the effects which could result from health care funding to the community. They could see the complexity of relationships which resulted from the health service investing locally, as Tracey points out:

*The butcher here had the tender for meat ... that’s not an inconsiderable sum of money for their business and we rely on them to support us when we have raffles or fundraising things and yet [now] we don’t order meat from him. I knew the guy personally and I was really embarrassed when they took the meat tender off him, I*
just thought, ‘How can I go in there?’ He had to give up one of his employees because it made such a big financial impact on him ... it doesn’t promote those relations between the community and the facility. I don’t feel that I can defend that decision as a person (Tracey, Manager).

Another difference between local and external perspectives became apparent when participants were discussing suggestions which were made for raising additional funds for the multi-purpose service development. For instance some rural health services had large tracts of land and experts suggested selling some of the ‘surplus’ land to raise money for further capital works. Not only did local participants know immediately that raising money through land sales would be unsuccessful, but they also questioned the values which prompted such a suggestion:

*They were going to sell the front off ... people come in the hospital from cities and that and, ‘Oh, what a beautiful view!’ And they look out the other side and they can see possums, kangaroos and everything at dusk and the birds ... we’ll get a syndicate, and they’ll put it into so many blocks, but we’ll get the town to join up and we’ll buy it ... these government people think that up there’s worth probably millions, but if you can get ten thousand for a building block in [local community], you’re lucky (Peter, Community Member).*

The health service always maintained the dominant role in any merger that took place but, as Peter indicates in the previous quote, participants were not totally powerless. Small pre-existing service providers with independent funding gave up part or all of their facilities to the health service along with the funding they relied upon. Giving up funding or facilities diminished the power and influence of participants who had previously been able to directly access decision makers in the much smaller pre-existing services.
Economic issues usually led to increased power for the stakeholders who were in control of the greatest funding. Frequently control of funding reinforced the reliance which small rural communities had on ‘external’ government decision makers. As small pre-existing services merged with the health service, issues of ownership became apparent.

6.1.3 Ownership

The final property of the phase, driving change, was a feeling of ownership. Many participants had developed feelings of ownership of ‘their’ health service through a close and lengthy involvement in it. However, ownership became a contentious issue when a change in the health service was to be implemented. A feeling of ownership did not equate to decision making ability, which frequently led to frustration among participants. This property gave recognition to the major role in any change, which participants felt the owners of the health service would be expected to play: making decisions and driving change.

Participants spoke about ‘their’ health service as local health services. The services were a source of pride to participants and they were extremely protective of them. Some of their sense of ownership came from repeated involvement with the health service, in the form of local fundraisers. Being proud became particularly apparent when a merger was to occur with the area health service as the area health service was managed from a regional city. Aileen points out that:

*Some of the community were upset with the fundraisers that they had, because the money went to [city] ... And they couldn’t understand that the town money [local...*
Participants described rhetoric in government documents which indicated that the community ‘owned’ the health service and invited representatives to engage in the multi-purpose service development. Paradoxically, decision making ability implied that governments retained that ownership, merely providing the illusion of local control. Some community members on health service committees described the lack of decision making power which these community representative committees experienced:

*When you made suggestions on the Health Council there was nothing ... we’d make suggestions, but nothing would happen (Jeff, Community Member).*

Even when communities were successful in *driving change*, the surprise this created among participants implied that communities did not usually have so much control over the health service. For instance Bev revealed that:

*I’m* really surprised that [local community] has this facility because [city] is only twenty kilometres away and this little town must have had a forceful community committee at the time, it really should just have an ED [Emergency Department] ...instead its got eight acute beds, all private rooms, all with ensuites, a two-bed ED Department ... eleven long stay beds, all private rooms with ensuites ... That was obviously a very strong push from the community (Bev, Staff Member).

Participants who were health service managers also did not feel they had ownership of the facilities. These participants indicated that managerial opinions were not valued by other stakeholders, despite their intimate knowledge of the idiosyncrasies of their communities:
It’s in a peculiar situation in that we’re ... smack bang in the middle of nowhere but we tend to get a lot of feedback, or feeding in from [another area health service], from out that way, and also from down near [another town]. They tend to come this way, and see that was something when we went through the MPS planning process was the fact that the Commonwealth would not take any notice of those inflows (Jane, Manager).

When money had been raised locally, participants were suspicious that the money would disappear in the multi-purpose service development. Community members who had raised funds for their hospital or hostel saw the area health service taking over the services which included any money they had raised. Dorothy stated that:

When we were the hostel, we bought the block, it was the old house next door, we bought the old house and built the ... units ... and they took over, just sort of took that apart. They didn’t give us any money back, refund any money or anything ... there was a great argument, oh a terrific argument about what we paid, who paid it and everything like that and I think [now] it’s a peppercorn rental (Dorothy, Community Member).

The lease of community-owned services (e.g. hostels), even through a minimal ‘peppercorn’ rental, was perceived by participants to imply that the community had owned them in the past. The nature of a peppercorn rental was perceived by participants as though they were giving up their ‘viable’ entities for worthless results (peppercorns) to business groups (the area health service):

We did have a hostel, a very viable hostel that belonged to the community and I think this is part of the opposition because the money, the government or the area health service rent the hostel from us for a peppercorn rent (Christine, Community Member).
As Christine explains, some community members were suspicious that the area health service would dispose of these assets once they gained control of them and the community would be left with nothing:

_The community actually owns the hostel building and a lot of the older members said ‘Oh, gosh, you know we’ll lose all the money.’ And [we] said, ‘No because you still own the building. It will be sold and the money will be donated back to the community because the area health service only pay a peppercorn rent on it’ ... they don’t realise that it’s in writing and they’ve been told a thousand times but they don’t hear it (Christine, Community Member)._  

Negotiating a peppercorn rental clearly indicated to participants that the community was a pre-existing owner of some services (usually hostels), but not of the resultant multi-purpose service. The community with which the rental was negotiated was signing over that ownership to the area health service; it was the area health service that was developing the multi-purpose service. The participants implied that ownership of the new health service would cease.

6.1.4 Impact of Anticipation of Risk

The core category _Anticipation of Risk_ impacted on the initial phase of _driving change_. When participants anticipated the risks involved in the development of the multi-purpose service, they frequently reflected on their past experiences with other stakeholders in order to judge the motives of those stakeholders. When there was a necessity to deal with people external to their own community, judgment of motive was often based on the history of the health service. Many small rural hospitals had histories of providing services such as operating theatres and maternity units which had been closed within the life span of participants. As part of a community which had benefited
from these services, many participants concluded that external drivers of change were motivated by apathy or self-interest. When participants were dealing with local stakeholders, they also judged their motives based on their shared backgrounds, which frequently involved successful fundraising activities to develop low-level aged care facilities.

The dimensions of trust or suspicion were not absolutes, but rather functioned as a continuum. In this phase of driving change, the continuum was affected by whether the stakeholders had a local or external background. In the following example, the recommendation for the multi-purpose service came from an external source, but community members (locals) intervened to control the risks they perceived when their trust was broken by long delays:

*The recommendation came back that we have a new facility and we were put on a priority list ... we were second or third in line and anyway we eventually came near the top and nothing happened, so we decided that we’d write to the Telegraph ... anyway all of a sudden within a week everything happened (George, Community Member).*

These dimensions of trust and suspicion which were associated with the core category were prominent in the first phase of driving change. In this phase they manifested themselves as a trust of local drivers and a suspicion of external drivers of change.

**Trust**

Local drivers of change were described by participants as those drivers that existed within the community where the multi-purpose service was being developed. Participants shared a mutual history with local stakeholders and found them easier to
access than external drivers of change. This mutual history and ease of access increased the trust which participants had in local drivers of change.

Some local communities had a history of being self-sufficient due to the efforts of community members. George was a trusted member of his community; not only had he been involved in fundraising to build the local aged care hostel, but he had a reputation of finding solutions to problems. He described the issues involved in choosing a site for the hostel:

*When we first looked, we wanted to build the hostel over there [hospital site] and New South Wales Health said, ‘No, you can’t go over there.’ ... So that was rejected, then we thought well, we go to the next place. We looked at a block of land reasonably central to the town and that’s where we built the hostel (George, Community Member).*

In this community, New South Wales Health rejected an initial community proposal for an aged care hostel to be built on the site of the original hospital, despite the site being large enough to accommodate the facility. When the new multi-purpose service was proposed, the decision was made to extend the more contemporary aged care hostel building and demolish the antiquated hospital building. Developing the multi-purpose service then required buying additional land next to the hostel as that site was not large enough for both services. This history provided an insight into why George, as a local, engendered more trust than external decision makers (New South Wales Health). From a community perspective, the past was an important insight into the future indicating whether they could trust in the health service to meet their needs.
A degree of self-reliance was described by many participants and perceived to be related to the isolation which they associated with rural communities. Participants discussed the close-knit nature of their towns. In contrast to external drivers of change, who were perceived by participants as portraying themselves as impartial and without prejudice, local drivers of change openly valued their degree of bias. As Peter stated in the following example, participants valued their community above others and were happy to ‘fight’ for it:

It depends on how good a fighter you’ve got in your town. That’s it; it all goes back to that. [Neighbouring community] should have been [developed as a multi-purpose service] in front of us, but … did they do anything about it? Did they wait for someone else to make the move? If you want something, you’ve got to go after it and that’s what we done up there (Peter, Community Member).

As Peter indicated in the previous example, local participants valued their own communities to such an extent, that other communities could be disadvantaged. In his description the neighbouring community did not have the resources, the ‘fighters’ that his community had. In this description trusting local stakeholders did not lead to an equitable outcome, as the more vocal community attracted resources away from a less vocal community. In a similar example, Ruth described a community she was involved with:

Their admission rate was just, maybe one a month if they’re unlucky enough and they got four acute beds and they fought for four acute beds and they got four acute beds. So the Department of Health actually found extra money for them (Ruth, Manager).

Despite the inequities which were created by trusting local stakeholders to advocate for themselves, participants described trust as increasing the pace of the development.
When participants trusted other people who were involved in the development of the multi-purpose service, fewer people were required to make decisions and discuss options. In contrast suspicion ensured that the opinions of a greater variety of stakeholders were heard.

Suspicion

In this initial phase of driving change, suspicion was frequently associated with external drivers of change. According to participants, external drivers of change consisted of stakeholders who were outside the local community and who made decisions about the multi-purpose service. Many participants indicated that these external drivers often did not have the best interests of the community at heart which led participants to anticipate risk and thus create suspicion.

Frequently the external drivers of change were government agencies. The initial locations for the development of multi-purpose services were identified by the New South Wales Ministerial Advisory Committee on Health Services in Smaller Towns, led by Mr Ian Sinclair. The Advisory Committee with its ability to identify locations which would receive funding was a significant external driver. Participants described some local stakeholders who anticipated the risk of losing their health service during the early stages of the development and managed to intervene in an attempt to control that risk, as the following example revealed:

*When the Sinclair Report first came out, [local community] wasn’t on the visiting list, but that little committee jumped up and down and they rang up Mr Sinclair and said, ‘We want to be on your visiting list, come and see us.’ So Mr Sinclair and his little entourage did and Mr Sinclair in his report said ‘[Local community]*
only needs to be a band aid station’... which didn’t go down well with anybody, so then we got ministerials and all sorts of things happening until they got put back on the MPS Program (Ruth, Manager).

In the community described by Ruth suspicion increased about prospective service reductions. This increased suspicion created delays as the community lobbied for increased services. Despite increasing delays, the suspicion described in the previous excerpt was the impetus for the members of that community to ensure their voices were heard. In this example suspicion had a positive impact for the community which was able to intervene early enough to overcome the decision to reduce its services.

External drivers of change were considered by participants to be essential for multi-purpose service development to occur due to their ability to provide funding. Despite the positive nature of providing funding, participant suspicion could not only cause delays, but through effective lobbying could even overturn these decisions.

The Commonwealth Government (another external driver) used a formula which took into account the size of community populations and their isolation to determine how much funding would be provided to a health service to meet the aged care needs of a community. This funding formula was known by participants, as Julie described:

*There’s three components to the rates for each place. There’s a basic rate for high care or low care which goes up each year, indexation … there’s a second component which is called the concessional residents subsidy equivalent amount … the third component is the viability supplement which is an amount which is based on two factors. One is their remoteness and the other is their size (Julie, Manager).*
As an external driver the Commonwealth Government relied on demographic data to determine the extent of funding support for health services. Although it was designed to be an independent and transparent means of allocating funding, demographic statistics did not engender trust among participants. Participants indicated that political boundaries were abstract and did not take into account the unique features of their communities, as stated by Jane:

They just drew lines on a map and said, ‘No this is your feed and this is the ACAT [Aged Care Assessment Team] assessments that have happened and this is all you are going to get.’ … we weren’t getting oldies from our area, we were getting oldies from everywhere else … but the Commonwealth did not want to know about that. It was those lines on the map and that was it. No one went over [the lines on] that map. That was really unrealistic and quite unfair (Jane, Manager).

The use of statistics met with criticism as participants argued for outcomes which were more congruent with their perceptions of their individual communities. Participants, such as Kate, felt that community populations were not stable and that governments were not planning for the future:

I see [local community] as a town, which is growing, and was perhaps downsized a little bit quickly (Kate, Staff Member).

The presence of suspicion created delays, but allowed participants to identify problems which they could deal with. Generally when external drivers provided the impetus to become a multi-purpose service, participants were more likely to be suspicious of the result, whereas at the opposite end of the continuum, local influences were more likely to engender trust among participants.
The properties of the phase of *driving change* (recognising the need for services, economic issues and ownership) set the scene for how interaction would proceed in the following phase when participants were actively engaged in the development of the multi-purpose service. In the second phase of *engaging with stakeholders*, local enthusiasm was more highly valued as participation was invited in the development of the new health service.

6.2 Engaging with Stakeholders

*Engaging with stakeholders* was the second and largest phase of the basic social process ‘Developing a Collaborative Rural Health Service Identity’. Participants reported this phase involved the major ‘work’ of the process; it began after commitment to the process had been established (*driving change*) and progressed into the final phase where the multi-purpose service was completed. This phase consisted of four properties: being part of a rural community, the health service hierarchy, peer support and the time taken to complete the development (see Table 9).

The phase *engaging with stakeholders* focused on participants, their interactions and relationships with stakeholders and others. The groups that participants felt were significant in this phase form the properties: their community, the health service and their peers. Participants perceived this to be the phase in which most stakeholder involvement was sought, usually in the form of consultation.
Table 9: Properties and Dimensions of Engaging with Stakeholders

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<th>Engaging with Stakeholders</th>
<th>Properties</th>
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This phase also reflected the core category, *Anticipation of Risk*. As discussed in Chapter Seven (Section 7.2.2), when participants judged other stakeholders to be altruistic they were more likely to be trusted giving them a greater degree of influence. However, stakeholders perceived by participants to be motivated by apathy or self-interest were more likely to be treated with *suspicion* and participants attempted to limit those stakeholders to a superficial, insignificant role. Each of these properties and the impact of the core category on this second phase will now be described in greater detail.

### 6.2.1 Being Part of a Rural Community

The first property of the phase *engaging with stakeholders* was being part of a rural community. Being part of a rural community was important for many participants, regardless of whether they were community members, managers or staff members. For many locations where participants were recruited from, this property led to the formation of the community committees which would play a large part in the phase *engaging with stakeholders*. 
This property was important to participants who felt a need to trust others within their community, but one they did not think was understood by people living in larger communities. George made assumptions about other communities, based on their size; he demonstrated his confidence that people would support each other merely because they lived in a small community:

*If anything happens, if you have a major catastrophe in the community ... You know everyone will support that person, family, whatever the situation* (George, Community Member).

Community members were not the only participants who valued this connection of being part of a rural community. Managers and staff members felt they were also part of the community; several were related to active members of the community:

*The community built this [hostel], my husband was one of them* (Barbara, Staff Member).

Many staff members and managers lived in the community and believed that they too were part of the community and should also have a voice on community committees. Despite believing that they were part of the community, some staff members and managers felt that employees of the health service had been unwelcome on the community representative committees which were formed to involve the community in developing the multi-purpose service:

*Question: So, no staff on the steering committee?*

*No ... no. What a good idea having a staff member on there [sarcastic tone], like the HSM [Health Service Manager] wasn’t even on there. I mean she wasn’t part of the steering committee ... why?* (Tracey, Manager).
This sentiment was reinforced by Jeff, a community member:

_I know that there were some nurses who applied; they would have been good, because they have a wealth of knowledge about health and how things are done ... they were discouraged; they didn’t want them at all (Jeff, Community Member)._ 

Bev, a registered nurse, worked at two health services while they were involved in being developed as multi-purpose services and described the need for local management to maintain a community presence, bridging the gap between the hospital and the community. At one location connection with the community was undermined when there was a high turnover of local managers as they were promoted in the area health service hierarchy:

_[Manager] had worked in a lot of places and was on her way up. It was quite clear that she had an agenda. And that was fine, good luck to her, you know that was what she wanted, but it was, it can make the community quite unstable (Bev, Staff Member)._ 

Participants revealed that communities preferred stability such as a local manager who had been working in the community for a number of years. The longevity of the manager maintained the respect and confidence of the community:

_Sh she has actually been a registered nurse at the hospital at [local community], since she got married, twenty-five years ago. So, she is from the community, yes ... and her husband’s a business man in town, and all those sorts of things. Everyone knows them and – you know one of those sort of nice fuzzy feel good things [chuckles] ... Well, that makes a big difference, and it also maintains the respect of the community and the confidence ... I think that’s also important (Bev, Staff Member)._ 

Participants who were health service managers also felt the pressure to be part of the rural community in order to be accepted in their role as manager of the local hospital.
Some managers such as Ruth, who were required to manage more than one small health service, found being part of the rural community to be difficult. Being a part of the local community was frequently perceived by participants to be related to where a manager lived and it was impossible to live in more than one community simultaneously. Ruth stated that:

*I don’t come from that town and I don’t live there and yeah I’m one of them ... I mean even though I’ve been going there for ten years they still saw me as, as being the enemy* (Ruth, Manager).

Participants indicated that being part of the local rural community involved reciprocity of trust – not only were participants likely to trust someone who lived locally, but they also felt the need to be trusted by locals. One way participants demonstrated their trustworthiness to the rest of the community was by being involved in the health service. When the proposed development of the multi-purpose service had negative consequences for some members of the community, participants who felt they were part of the local rural community reported feeling torn, unable to act in everyone’s best interests. George was always keen to further the development of the multi-purpose service which he felt had benefits for his community, but felt the repercussions when even one family suffered due to the development:

*There was a fair bit of ill feeling. You’re taking our house. You know my father lived here and oh, gosh, you know ... but the house was buggered, but that was beside the point, you know* (George, Community Member).

Participants indicated that both the government and health service acknowledged the need for community participation in the development of the multi-purpose service.
Frequently community participation resulted in the formation of community committees to advise the health service on community needs, which was referred to as community consultation. Participants who were managers described a variety of selection procedures at the different locations they worked at. Participants frequently compared the community committees which were formed to assist in the development of the multi-purpose service to previous hospital boards which had been significantly more influential. For instance Jeff described that:

_The Board was better ... when you were on the Board you could get things done. When we were on the Board we would make suggestions and take them to the CEO and more often than not we would get what we suggested, but when we were on the Health Council ... nothing would happen (Jeff, Community Member)._  

Despite acknowledging the need for a wide representation of committee members, some participants expressed the opinion that there could be too many members or members who would not be appropriate. Peter suggested that some committee members were more valuable than others because they knew the right people:

_He’d come up with some good ideas and I think someone, his friends would go and have a yarn to the Minister for Health, or one of his under strappers (Peter, Community Member)._  

Peter also suggests that when committees had a broad representation of community groups, the committee would have the support of the community:

_We’ve got our ... the town on side ... You’ve got to ... our committee, is mixed, we’re, you know, some are out of town, some are in town, and we’re in different organisations (Peter, Community Member)._
This property of being part of a rural community with its emphasis on forming a community committee was significant in the phase *engaging with stakeholders*. All participants who lived in the community regardless of whether they were a manager, staff member or community member spoke about the importance of the community committee and how it was used to ‘sell’ the concept of a multi-purpose service to the community. Jane, a manager, stated:

*The Health Council went out to the community and basically got focus groups and had a lot of information meetings and bits and pieces and they sold the concept to the community (Jane, Manager).*

The property of being part of a rural community reveals the relevance of rurality to the participants. The following property of working with the health service hierarchy describes the relationship between participants and the health service which managed the new multi-purpose service.

6.2.2 *Working with the Health Service Hierarchy*

The second property of the phase *engaging with stakeholders* involved the interactions between the health service hierarchy and the participants who were interviewed. The health service hierarchy was a structure that had been established for many years as part of the pre-existing hospital and the area health service before the multi-purpose service was considered. It was a powerful entity in these small communities. The health service was relied on to provide services to meet the acute health care needs in each community. It was also in a central position for the development of multi-purpose services, as Julie pointed out:
We have fairly strong protocols that New South Wales Health likes most communication to go through them, so anything official about place numbers, renegotiation of agreements, service planning anything like that. It all comes through New South Wales Health (Julie, Manager).

Generally managers and other members of the hierarchy were well respected by participants as having the skills and education appropriate to their role:

She guides us actually and she, you know she knows the rules and all the regulations and everything else (Dorothy, Community Member).

Other pre-existing health services were not part of this hierarchy and frequently perceived the health service as being large and impersonal. Dorothy had previously been part of the hostel board and described some of the changes which occurred as the health service hierarchy took control:

We used to meet monthly, knew the patients, knew the people you know and everything, that doesn’t happen anymore (Dorothy, Community Member).

Participants described the area health service hierarchy as a large entity with numerous sections of staff. The size of the health service appeared to lead to divisions or factions where some factions were more highly regarded than others. One of these divisions was between the acute care staff and allied health staff, as Lyn indicates:

The acute staff were mostly, were just more, were strong ... they just didn’t really understand what a multi-purpose service was themselves so they were wanting a new hospital and that was the voice that was heard (Lyn, Staff Member).

Many participants described managers being given additional work in areas that were unfamiliar. For some managers who participated in this study, the additional workload was not problematic, due to the support they were given by the area health service:
Everything that I was asked to do there was support for (Fiona, Manager).

Other managers, who were interviewed, would have liked greater support from experts within the health service hierarchy about staffing classifications, health service protocols or the purchase of equipment. Ruth for instance states that:

I was chasing up you know what was on contract and where could I get the best fridge for the morgue from and you know by the time you did ten phone calls and you found out, okay they’re not putting fridges in morgues anymore, they’re putting cool rooms in now, so that was a waste of time [laughs]. So, there was a lot of probably wasted hours of me on the phone chasing, you know who had contracts for, for various things, like drug fridges and fridges and TVs (Ruth, Manager).

The health service hierarchy controlled the budget including money for staffing and furniture, fittings and equipment (FF & E), but did not always provide local managers with accurate details of what their budgets entailed. One participant spoke about the lack of information which she as a manager received from the health service hierarchy. Jane said that:

I was told we had no FF & E left and then last year we had a lightning strike ... and it basically cooked everything here and then all of a sudden there was some FF & E money around and we were able to get a cool room, which was wonderful because we didn’t have a cool room, but you know it’s things like that. We went MPS in 2003, why was that money floating around for that length of time and why didn’t we get the whole of it before then? (Jane Manager)

Community members, when they were interviewed, also indicated that they were receiving little accurate information about money, as Christine says:

The money that was raised, the $72,000 or $74,000 that just sort of ended up in the swill somewhere ... the hospital said it was actually utilised to get some of the beds and things for the MPS. Now, not being in it anymore, I’m not quite sure
where it went. I do think they salvaged some of it, but a lot of it just went into the swill and that was a shame (Christine, Community Member).

In summary, the health service hierarchy was a powerful entity and all participants were required to engage with it. For many services which were previously community owned and managed, engaging with the health service hierarchy was a new experience. Participants described the health service hierarchy as large and impersonal and encountered factions of staff when they did engage with it. Some participants described the hierarchy as supportive, but others found it difficult to obtain accurate information from it. When peers were available for advice they could provide valuable information on how to deal with the hierarchy and other issues which arose in this phase.

6.2.3 Peer Support

The third property of the phase engaging with stakeholders was peer support. Participants identified that sometimes peer support was formally organised, for example, some area health services had regular meetings of health service managers involved in multi-purpose services. Other participants reported that some managers arranged for their steering committees to visit communities which already had established multi-purpose services. Other peer support was less formal, for example, some participants (community members) had friends or relatives in neighbouring towns and would communicate with them about the new development. When their multi-purpose service was complete, participants also described assisting stakeholders in other locations. Peter described peer support as:
Went to three [multi-purpose services] out there, they were up, some of them were up and running a bit earlier ... Well, they got a new hospital, and they multi-purpose all up and everything new and that's next to a little retirement village, but that was on after us, but I think a lot of others learnt from our hospital too (Peter, Community Member).

Some participants described how the area health service had established meetings for managers of proposed and established multi-purpose services to come together for support. Jane stated:

We try to get together at least once a year as a whole body of people and we can address issues at a forum, and I think that's a very valuable thing to do (Jane, Manager).

Other participants who were managers without this formal line of communication felt unsupported by their (different) area health service, which did not recognise the benefits of such meetings. One participant, who was a manager, identified the benefits of discussing models of health service delivery with other managers and involving other staff members when visiting established multi-purpose services. However the majority of participants who visited other multi-purpose services focused predominately on the physical features of what they wanted to emulate or to avoid at their location. Lyn reflected that:

They just seemed still always to be looking at the emergency room or the oxygen [laughs] ... just looking at the actual bricks and mortar and how it was spaced or where the sluices were or something, not the model of care behind it ... I don't think they had enough education on actual changing the mindset and the model of care, that I think should have been looked at more carefully (Lyn, Staff Member).

Participants described managers as encouraging some community members and staff members to visit other multi-purpose services, particularly when they had organised the
visit. Some committee members, however, developed their own networks of peer support without the sanction of managers. For instance Ruth stated that:

*A few of the committee members were visiting other MPSs to find out what happened there ... without letting anyone know what was going on ... very Secret Squirrel [laughs] and then they turned up at a meeting and they’d say, ‘Oh, but in [another community]’, or ‘in you know [another community]’ or wherever it is ‘they’ve got one’, or ‘this is what didn’t work there and we’re certainly not having it here’* (Ruth, Manager).

Peer groups were described by participants as providing support and information enabling members of the group to ‘*play the game*’ (Elizabeth, Staff Member) thereby improving their ability to influence the process. As George explained in the following excerpt, participants learnt from successful peers:

*I think we were on third priority or something like that, [another community] was below us and they jumped up and down and spoke to a couple of people and one person really, he was the MP and he jumped up and down. He’d been to see the local member sort of thing and we thought blow that, let’s have a go too* (George, Community Member).

In some cases peer support hastened the process of developing a multi-purpose service as participants reported that having contact with successful multi-purpose services increased their *trust* in the model. In other cases, however, when participants learnt of difficulties in the development they hesitated, suspicious that they too would have these issues, and created delays.

6.2.4 Time Taken

The final property of the phase *engaging with stakeholders* was the time taken to complete the development of a multi-purpose service. The time taken was variable in
length and was impacted upon by the core category of *Anticipation of Risk*. When participants trusted one another they described a team approach, which resulted in speeding up action, an ability to adapt and get the development moving. As Danielle stated:

*It was a really good partnership between community, staff, the area’s design construction people or architects and project manager from the area ... and we ended up getting extra funding because of our good strategy that was agreed upon, quickly by everyone so that worked really nicely (Danielle, Manager).*

Despite the acknowledgment that the development was progressing, participants were aware that there was much to be done. Several participants mentioned that the process took a long time. As Kim stated in the following excerpt:

*The whole process takes a lot of time. A number of years, and I suppose the thing is that people are a little bit misguided as to the time frame and, as you go through the process, the realisation occurs to you, that you know they’re telling you that in eighteen months you’ll have a facility, and in real terms that’s two and a half years down the track and so, you know, this Steering Committee can feel quite deflated at the fact that it’s not happening quickly enough (Kim, Manager).*

At some locations the development of the multi-purpose service involved the modification of an existing building. Such modification often seemed to be a lengthy process as only part of the work could be completed before staff members would be required to move into the completed section and allow the builders access to the section which they had previously occupied. Kate stated that:

*Oh, there was a lot of relocation. Like I can remember at [local community] I think I moved my actual outreach clinic about three or four times (Kate, Staff Member).*
Despite recognising the need for a lengthy time period for the development of the multi-purpose service, several participants identified this as inhibiting continuity of management of the project. Tracey for instance said that:

*I found it quite hard coming in at the later stage and finding out what had been done and where people, where all these little committees were up to and that probably was unfortunate that the management changed at that very crucial time* (Tracey, Manager).

Although the process could be lengthy, some participants felt that time was necessary in order to get a good outcome. As Ruth states:

*I don’t think the whole process can be all that rushed, you need very careful planning during the building process. You need a lot of involvement from all stakeholders that know exactly what’s going on where. If you have got an old place you need input from the previous owners, as to really what worked and what didn’t there, so you can fix that up ... a lot of investigating of what works, what doesn’t in other places to make sure what you’re doing is going to work and how* (Ruth, Manager).

The time taken to complete the development of a multi-purpose service was the final property of the phase *engaging with stakeholders*. The pace at which the development moved was variable in length and was impacted upon by the core category of *Anticipation of Risk*. Greater levels of *trust* among participants may have decreased the time taken, but sufficient time was required for participants to feel that they had been heard.

### 6.2.5 Impact of Anticipation of Risk

During the phase *engaging with stakeholders*, participants continued to focus on their core concern of *Anticipation of Risk*. As this phase focused on their interactions with
each other, they were again constantly judging each other’s motives and controlling the risks they perceived to arise from that judgment. The dimensions of suspicion and trust were expressed in this phase as the level of influence which participants perceived. Having a superficial or insignificant level of influence reflected the suspicion felt by participants during the development of a new health service identity.

Trust

The dimension of trust was apparent in the second phase of the basic social process and was reflected in the degree of influence which participants perceived they had. Some participants who were community members managed to rally support among the community ensuring that town meetings were frequently well attended, and organised by local community groups, where the formation of committees to represent them and to lobby for community interests occurred. Being selected to represent the community demonstrated the trust the community placed in these people and their influence within that community. For instance George describes that:

*We had a public meeting ... Anyway when they finished they voted unanimously, you know they formed a committee* (George, Community Member).

Some of these communities found themselves able to make decisions and to get what they wanted:

*When we did our service plan, that was part of it, whether we stayed in the old building, knocked it down completely and built a new facility or we went over and put it on the hostel and we had everything together ... And that was the two major things, and the decision was made that we go over to where the hostel is, buy the land and put it all together.*
Question: And it was your committee that made that decision?

Yeah, yeah, we made that decision (George, Community Member).

Trust was apparent in the second phase of the basic social process where it was reflected in the degree of influence which participants perceived they had. In contrast suspicion led to a superficial and insignificant engagement.

Suspicion

In this phase of engaging with stakeholders participants frequently associated suspicion with a lack of influence. Frequently participants reported that decision makers appeared to take time to obtain stakeholder opinions but that, in reality, participants saw those opinions discounted or ignored. Their level of influence was perceived as insignificant and their suspicion of the decision makers who were involved increased.

Many participants were suspicious of the consultation which occurred, frequently involving town meetings, surveys and asking various groups within the town for their input. Whenever community services were perceived to be under threat, large numbers of suspicious community members could be rallied to protest the expected decision. Consultation was promoted as a useful exercise, but the majority of participants felt that it was superficial and merely provided a veneer of involvement. Consultation obviously aimed to build trust, but had the opposite effect when participants felt that it had not been taken seriously:

They have the obligatory consultative processes, but have their own plan anyway. I think (Lyn, Staff Member).
[There] wasn’t a lot of consultation done with the rest of the staff (Michelle, Staff Member).

When consultation was perceived to be superficial, participants became suspicious of the people involved. Some participants described changes which occurred during the development of the multi-purpose service, but many felt that these changes had been limited or unrelated to the consultation. As Helen pointed out in the following excerpt:

[Residents] had to be consulted because look, they were concerned, they thought that they might lose their home and so it was done, they didn’t even realise that it happened when it happened. I had a couple of residents here that were quite sound minded and sort of asked me when we were changing over and I think we had been changed over about six months (Helen, Manager).

As Helen indicated in the previous excerpt, consultation was not always related to change. In other cases trust was broken (and suspicion developed) some time after the multi-purpose service development had been completed. As Peter stated:

We wanted rainwater, because you know, we’re not in an industrial area here, everyone, like, has water tanks in the town, but no, the Department of Health said no water tank, you’ve got to do this and now hospitals and that, government buildings they’ve come and put water tanks in. It’s a bit like shutting the gate after the horse has bolted isn’t it? (Peter, Community Member)

On the whole, many participants felt that consultation had been superficial. Participants assessed their engagement in the development of the multi-purpose service as being insignificant when their opinions had been sought, but ignored. Asking for community and staff opinion engendered trust, but this frequently decreased when decisions were made with little regard for these opinions and few explanations of how decisions had been reached. In contrast, the participants who felt they were more influential in this
second phase of the basic social process were more likely to trust other stakeholders as they entered the final phase of collaborating.

6.3 Collaborating

In this study participants perceived the development of the multi-purpose service model of health service delivery as requiring a change in the culture of the organisation. Cultural change occurred in an emergent fashion as all participants involved in the multi-purpose service participated in negotiating the new culture. Mergers were never mentioned in the data which was collected; instead, participants spoke of ‘coming on board’ (Christine, George, Community Members; Helen, Jane, Kim, Margaret, Tracey, Managers; Michelle, Staff Member), a term which indicated the inequality of the merging bodies. Sometimes this change occurred in ways that were not intended or predicted by the managers within the health service. Some participants indicated a need to ‘play the game’ (Elizabeth, Staff Member) using rhetoric which reduced the impact of change on their previous hospital identity. The new identity which was created was also closely linked to the physical change which had taken place and the degree of multi-skilling which was required. All health services had been officially gazetted as multi-purpose services when this research took place and every participant indicated that collaboration between pre-existing services had improved through the development of the multi-purpose service.

As with the other phases in this basic social process, the core category Anticipation of Risk impacted on this final phase. When participants were trusting of other stakeholders they were more likely to develop an integrated health service. In contrast those
participants who anticipated risk in collaborating with other stakeholders were more likely to be suspicious of each other and develop a relationship of coexistence.

The dimensions of this phase existed as a continuum where some participants embraced the change to a multi-purpose service, and moved to an integrated identity. Others accepted the change superficially, suspicious of the result and merely coexisted with each other. Coexistence was at one end of the continuum, involving the least amount of collaboration, the opposite of integration. This phase had four properties: multi-skilling, developing a new organisational identity, creating rhetoric to maintain a hospital identity and making physical change (see Table 10).

Table 10: Properties and Dimensions of Collaborating

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<td>Making physical change</td>
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6.3.1 Multi-skilling

The first property of the final phase collaborating was multi-skilling. Participants reported that changes in skill mix were commonly required when the multi-purpose services were developed but funding was rarely increased and staff members were usually assured they would keep their employment. Participants described multi-purpose services as requiring a greater range of skills from staff members than the
health service which had employed them previously. For many participants, it was the ‘staff [who] made the multi-purpose service’ (Tracey, Manager). Like other properties, multi-skilling in itself was neither positive nor negative. Some participants who were staff members enjoyed the opportunity to develop additional skills while others felt threatened when asked to do so. Participants identified that greater levels of multi-skilling among staff members seemed to lead to a greater degree of integration for services within the multi-purpose service. Elizabeth described the increased pressure to develop more than one skill:

*The multi-skilling side of things ... We’re being asked to be credentialled and excelling in too many situations ... I think general knowledge is a great thing but we’re just becoming so diverse with everything that we have to be able to cope with any accident and emergency and aged care nursing – they’re all such specialised areas (Elizabeth, Staff Member).*

Many small rural health services had been providing a variety of health services prior to being developed as multi-purpose services. The additional focus on being multi-skilled which came from the new model of health service delivery was identified as being a concern by several staff members. The following example is provided by Jane, demonstrating a lack of trust in multi-skilling:

*The nursing staff in general feel torn between both areas and a lot of the staff here are related in some way to the oldies. So, I mean, they absolutely adore them and they want to give them their best but unfortunately the acute side of things can get very pressing. That can be a real issue, and I think that does create quite a bit of stress ... they feel really guilty because here they are, they’re trying to save this other person in, in A and E [Accident and Emergency], or whatever, and you know, Uncle Bill is stuck on the toilet and they can’t get there (Jane, Manager).*
Jane’s description of multi-skilling indicated issues of limited time. According to Margaret, a manager, some staff members were not as keen to multi-skill. She said that:

Some staff never accepted the change. Some did not want to do aged care, which made it difficult for them. Some staff have adapted with education and some left (Margaret, Manager).

The ability to multi-skill allowed a multi-purpose service to provide a variety of services with limited staff. The differences in how staff members reacted to the need to multi-skill meant that the success of the multi-purpose service often relied on individual staff members. When multi-purpose services were successful, managers frequently indicated the value of their staff, as in these excerpts:

I think that MPSs do work, we’ve got ours working in a fashion but only because we’ve got really good people on the ground (Jane, Manager).

The nursing staff are … so multi-skilled and … advanced skills. Really, really good in an emergency and you know, you would put your life in their hands and I just took my hat off to them … they are so valuable and that’s why it works so well (Tracey, Manager).

These managers were aware that it was their staff which had made the new model of health service delivery a success. However, in rural areas it was difficult to find such valuable employees. As a manager Jane described her struggle to find a suitably qualified mix of staff to provide the variety of services she knew were required in her community:

Looking at the types of staff and what they do would have been a very good process … it would have given me more leverage to say, ‘Well look hang on a minute I need more staff’ and I know that at [neighbouring community] MPS they went through a staffing review and they ended up getting more staff, but we had to fight tooth and nail to get any kind of increase in any staff (Jane, Manager).
Having sufficient and suitably qualified staff was essential to a well functioning multi-purpose service. Even community members acknowledged that it was difficult to get staff members who were multi-skilled. For instance George described that:

_We have an x-ray facility which is fairly archaic and fairly limited but we don’t have the operators with the training qualification. I think [staff member] has it ... Yes. I think basically we need more like that_ (George, Community Member).

Despite being unclear about the qualifications staff had, even community members described situations where suitably qualified staff members were sometimes, but not always, available. Not only was this viewed as a logistics issue, but community members were also aware of the pressure being placed on staff members who were in situations they were unqualified for. As Jeff indicates:

_Some days they’ll have an RN and two ENs, but sometimes they have two AINs. They do more than they’re supposed to ... They give out medications and they’re not supposed to. The ENs that have done the course can give them out so when they can’t get staff and they have two AINs on, the AINs have to give out the medications, they just feel that they have to, because they can’t get the staff and management know, but just look away, they don’t do anything_ (Jeff, Community Member).

Participants realised the difficulties which existed in attempting to attract and retain staff and commented on how lucky they were to have them. The isolation faced by many of these communities was seen to impact upon their ability to attract staff from other areas. As George pointed out:

_We get used to driving from here to there ... But a lot of people coming from the city think, ‘Fancy driving an hour!’ _ (George, Community Member).
Participants were aware that recruiting staff was difficult in rural areas and often had long-term impacts on these health services before they became multi-purpose services. Participants who were staff members particularly perceived the strategy of multi-skilling to be a method of dealing with recruitment and retention issues. Frequently they did not trust this strategy.

Participants were able to separate the shortage of available staff from the issue of funding for sufficient numbers of staff. When there was a shortage of staff, positions would be advertised, but no one would apply. In comparison when funding was unavailable, existing staff felt they were stuck in their current situation with no possibility of change. A lack of funding denied participants who were staff members recognition of their reality – if managers too believed they were short of staff they would find funding and advertise to employ more staff, as Sonia pointed out:

> *Even if we can’t get them, we have the right to advertise for them and expect them* (Sonia, Staff Member).

As these previous excerpts indicate, multi-skilling was expected in most multi-purpose services with staff members expected to work in more than one area (e.g. aged care and acute care). However, some participants described locations where multi-skilling was minimised. In order to minimise the degree of multi-skilling required, some multi-purpose services employed staff members who were limited in their roles (e.g. aged care). Limited rather than multi-skilled roles were felt by participants to be especially common in those multi-purpose services which functioned over more than one site. As Jenny pointed out:
Participants saw one of the major benefits of the new multi-purpose service as being the improvement in aged care services. For those locations which did not previously provide aged care, it was particularly significant as Peter pointed out:

*If we didn’t have it, a lot of these people would have to go out of town and these older people, when they’re out of town, they fret ... [multi-purpose service is] still home, you’re still in your own town* (Peter, Community Member).

For many staff members the changes to their skills and the skill mix of staff employed at the new multi-purpose service impacted on their understanding of the new model of health service delivery.

### 6.3.2 Developing a New Organisational Identity

The second property of the phase *collaborating* was developing a new organisational identity. The term ‘multi-purpose service’ was used from the beginning of the development; it nevertheless appeared that most participants had not anticipated a change in the model of health service delivery being used. On numerous occasions participants referred to the new health service as a hospital rather than a multi-purpose service. As Jane points out, it was in this final stage of the process where identity became an issue:

*It doesn’t really describe what it is. People felt that they were losing their hospital ... we’re gazetted as [local community] MPS. Now that says nothing about a hospital* (Jane, Manager).
As time passed the concept of multi-purpose services became more acceptable to some communities as the novelty of the new health service faded and more multi-purpose services were developed in other towns. Lee described one particular community:

*They have had an opportunity to see their neighbouring, you know, towns and that builds trust [in the multi-purpose service]* (Lee, Manager).

When the multi-purpose service was completed, participants had the ability to portray themselves as ‘expert’ in some roles. A sense of pride in their accomplishments increased their cohesion, as Dorothy pointed out:

*Men’s Health Night] is something that we’re proud of, and because everyone else now is just taking it up … Tim Fischer on the television and the Masonic people, and Jeff Kennett, and …* (Dorothy, Community Member).

One staff member described what could be achieved when a multi-purpose service model was adopted:

*Hospitals you always have the illness model, like everyone’s ill, but at [local community] because it was the new design, there was a real feeling of wellness, because you came into the clinics as well. Does that make sense? You didn’t actually just visit the facility when you were unwell. The early childhood nurse ran her clinic, the speechie, the OT [occupational therapist]. The GP [general practitioner] was actually based in the centre as well; they ducked in and out for their blood tests* (Bev, Staff Member).

Many participants agreed that the concept was a good one and should be embraced although they were not sure to what extent this had occurred. Julie questioned how much change had actually occurred:
The real issue I think at the level of the services is whether the service model has actually changed in terms of what, how staff are working and how the services are being provided (Julie, Manager).

Participants described how they developed an understanding of the multi-purpose service model. Several participants described attending education sessions, which differed in each location. Some described education sessions combining staff and community members. Most sessions were described as having occurred early in the process of the development. In this later stage of the process, gaps in knowledge had become apparent. As Barbara pointed out, educating such a variety of people could be difficult:

Yeah, there were fliers, there was ... I think there was in these little towns, it's very hard to bring it to people's knowledge, but yes, I think there was, there were fliers went out to tell you what it was, and explained it and they did have meetings too, for people to go to, listen to, explain what it was (Barbara, Staff Member).

Despite Barbara’s acknowledgment that it was often difficult to increase knowledge about new concepts within the community, responsibility for such knowledge was not taken by the participants. Instead participants indicated that individuals needed to take responsibility for their own knowledge and understanding of the multi-purpose service model, particularly within the community:

Question: Do you think that everybody understands what a multi-purpose service is?

The ones that want to, the ones that want to (Peter, Community Member).

This response from Peter indicates that understanding the change was not essential for all community members. When some community members supported the development,
it was able to continue without consensus from all. The perception that a few community members were representative of the entire community may explain why it was frequently not embraced by the entire community.

Some multi-purpose services which participants described were formed by extending the services provided by the health services and did not involve a merger of existing services. However, many multi-purpose services which were described by participants in the study involved a merger (or acquisition) of pre-existing health services in their development. The benefit of having a good relationship with those organisations which were acquired in the merger prior to the development of the multi-purpose service was identified by a health service manager:

_They knew we were there for them and that they could interact with us and they found that very, very helpful and there was quite a good information exchange between the hostel and us here, so I tried very hard, very hard to foster a good relationship, and we did have one, and so that made the transition a lot easier (Jane, Manager)._ 

Although a new organisational identity was formed at some locations, not all embraced the new model of health service delivery. Instead some participants spoke of multi-purpose services where stakeholders had developed a rhetoric which sheltered their hospital identity.

### 6.3.3 Maintaining a Hospital Identity

The third property of the phase _collaborating_ was maintaining a hospital identity. Some participants were confused about what the multi-purpose service model entailed; identifying health services they had worked in as being multi-purpose services when
they were not. Others realised what the multi-purpose service model entailed but felt that their health service had not embraced this change and were ‘still hospitals’ (Sue, Staff Member). Some participants even felt that they were working in a unique environment (which was a major requirement of multi-purpose services), but that their service had not yet truly attained ‘multi-purpose status’ [emphasis from Kate] (Kate, Staff Member).

Many participants used the word ‘hospital’ to describe the multi-purpose service at some stage during their interview. Some participants had attempted to make the change, but were thwarted by a lack of understanding within the community and health system which resulted in them reverting to more common terminology for ease of communication:

> When we’re ringing up MRU [Medical Retrieval Unit] or we’re ringing up Royal Flying Doctor or anywhere like that, if you say an MPS they don’t know, because, I, you just, I just call it [local community] health service (Sue, Staff Member).

Even when the new model of health service delivery had been adopted and had been in place for several years, participants described ongoing difficulties in their interactions with other people in the health system who had still not been exposed to the concept. Many participants found the limited understanding of the multi-purpose service model to be frustrating. As Jane stated:

> We tend to pull our hair out quite often. In fact we have new items, medical record patient identifier numbers or planning, all the information in the acute section went over beautifully ... not the MPS section, all the RAC [Residential Aged Care] numbers and all the other stuff wouldn’t transfer over in the system ... At all, no. It wasn’t capable; once again the system is only catering for the acute side, and not the MPS side (Jane, Manager).
In this way participants began with the intention of educating others, but found instead that they were being educated. They perceived an underlying resilience of the health system which inhibited their ability to change this fundamental detail of health service identity. The word hospital in many of these communities was perceived by participants to be synonymous with health, and taking it away to be replaced with a term as broad as ‘multi-purpose service’ caused suspicion, particularly when everyone was unsure of what the change would entail. As Sue pointed out in this excerpt, the concept of a multi-purpose service was poorly understood:

_There’s not a lot of information, when we went from the hospital to the MPS, we were never really sat down and explained to what the full concept is, so staff were struggling because we were never given the idea exactly what it is (Sue, Staff Member)._ 

One participant described several multi-purpose services she had worked in, including amongst them one which was not a multi-purpose service:

_I guess it wasn’t called the [local community], it might be called the [local community] multi-purpose hos … I don’t know what it’s called now, sorry. Yeah. But it’s that sort of a model (Bev, Staff Member)._ 

Most participants indicated that the multi-purpose service model required a change in thinking which they agreed was not apparent amongst all stakeholders involved in the development. The majority of participants believed that the change in name should herald other changes. These participants, such as Jeff, frequently commented when they perceived cultural change had not occurred:

_I look at the hospital and not much has changed from when I started here about thirty years ago. It may have a new coat of paint, but it’s still the same … Still a_
hospital. It hasn’t changed. Some things they change, they just change the name ...

... Multi-purpose has to be multi-purpose, it’s like I said, it’s no good just changing the name (Jeff, Community Member).

Some participants described a limited understanding of the multi-purpose service concept from the beginning, which they felt inhibited their ability to embrace the concept. Often staff described the process as ‘evolving’ when they felt it should have been driven by people with greater knowledge of how to make it work. As Lyn stated:

Thinking about just the lack of really proper understanding during the planning process of the people involved of what the idea was, is probably a big part of how it develops and that is quite obvious looking, looking back that they really just didn’t get it (Lyn, Staff Member).

This lack of understanding about what a multi-purpose service was or could be, left participants feeling that they had been let down during their local development of the model. Lyn expressed the desire for more assistance throughout the process of developing the multi-purpose service in this excerpt:

Needing more guidance with making those decisions. They’re big sorts of decisions (Lyn, Staff Member).

Their understanding of what a multi-purpose service involved frequently came from education sessions provided by the health service, but this varied with some participants denying ever attending such sessions or being misinformed when they did. One staff member summed up the situation as:

I don’t think management even have the full idea. It’s just picked up from here and there. You know we’ve just kind of got through by the skin of our teeth. So I couldn’t exactly tell you what an MPS is supposed to be (Sue, Staff Member).
Some participants described locations which conceded to community demands that the original name of their hospital not be altered. Tracey described the situation at the multi-purpose service where she worked:

*So that’s how they’ve done it and that was decided by the Steering Committee and the Health Council, so they feel good that that was adopted. We haven’t even got MPS anywhere in our title (Tracey, Manager).*

Maintaining the title of the health service as hospital created confusion among participants. Another source of confusion was that communities without State Government funding were eligible to develop multi-purpose *centres* which often combined aged care facilities with a general practitioner:

*I have to correct people. ‘There is a difference between a service and a centre.’ ‘Oh, is there? Why?’ [laughs] ‘It’s all to do with funding and that, but you know we’re an MPS not an MPC.’ ‘Oh’ … ‘Okay’, then they walk away and still call it an MPC [laughs] (Ruth, Manager).*

To add to this confusion some local government councils created multi-purpose centres of their own which had no relation to health at all, but incorporated council facilities. Jane described the situation in the community where she worked:

*What the local council did was they set up Multi-purpose Centres to be one-stop shops, where you can pay your bills, and go to the library and this, that and the other, and unfortunately that concept got confused with the MPS concept (Jane, Manager).*

When participants were confused about what the new model of health service delivery entailed or felt they were being forced to accept a model they did not *trust*, they would
often develop rhetoric to give the impression that they were meeting their obligations in the development of their new multi-purpose service.

All the health services in this study were multi-purpose services but this model of health service delivery was not embraced by all participants. Some participants felt that the multi-purpose service model had been forced upon them and they had not developed trust in it, even after the service had been established for some time. Some of these participants felt that they had faced a threat to their hospital and had managed to benefit from it. The rhetoric that some participants engaged in ensured the best possible result for their community. Rhetoric was more obvious when participants discussed the limits of the change which had occurred, for example: ‘only the name changed’ (Jeff, Community Member) or ‘only the building changed’ (Dorothy, Community Member).

6.3.4 Making Physical Change

The final property of the phase collaborating was conceptualised as making physical change. For many participants this property was the concrete result at the end of a lengthy process. Often the biggest change to occur in the development of the multi-purpose service was a physical change. Some participants anticipated a change in the way services were to be delivered which was not perceived to have taken place. The new physical facilities had meanings for participants which impacted upon their acceptance of the new model of health service delivery. Many participants were pleased with the physical features as is revealed in the following interview excerpts:

*The people of the district are very, you know, it’s a beautiful, beautiful place (Dorothy, Community Member).*
One of the features that we have is out in the plant room, lovely big plant room, we've got room to back in through it. Its lovely, lots and lots of room, we have an actual wash bay which has an environmentally responsible waste system. In so far as that everything goes through a separator, and water and stuff will go out through the drain, but any oils or greases and things that come down through the ... the things are actually separated out. I mean it's not, it's a requirement nowadays but it's a lovely, lovely thing to have (Mary, Manager).

It had aged care, that was already in existence and they were able to incorporate and pull the two together really nicely, with a nice wide foyer, there was plenty of room for primary health care ... There was a terrific education room, there were clinical rooms and it tied in nicely to the acute section. There were rooms with ensuites, and they were big and airy, nice big windows, lots of sunlight, there was a garden out the back (Kate, Staff Member).

Other participants described the physical move from one site to another or into a refurnished section as a positive experience which offered the opportunity to build stronger relationships within their team. Ruth described the relocation of the multi-purpose service she was involved in as a positive experience, which created just such an opportunity to build team relationships:

Everyone wanted to be part of it because it was ... I think they all felt so involved from way back that they continued. You know that this is ours and we want it to work right. So ... we had put on barbeques, sausage sizzles and we fed everybody that turned up. ... Everyone was having a good time with everybody else, you could see them all inter mixing and, yeah comradeship was great (Ruth, Manager).

However, some participants were not so happy; particularly those who indicated that the multi-purpose service they were involved in had reinforced old divisions between groups of staff. In Lyn's case, the physical facility was seen to benefit a group which was positively regarded (acute care), although another group (allied health) which was not so well regarded was disadvantaged in the development:
The new building was for the acute inpatients and the long stay which was good ... but all the extra bits, all the other services were just told that they could have the old hospital bit and that it could be painted with a coat of paint if they were lucky. So we’re just given what was left over (Lyn, Staff Member).

Some of these staff members who participated in this study felt that such inequity in the distribution of resources was problematic as it reinforced the perception of the multi-purpose service as a hospital and continued the domination by the acute setting. The term ‘multi-purpose service’ suggested to these participants that the health service would be expanded to include health services which had not previously been available. In those circumstances where additional health services were not perceived to be valued equally, participants interpreted the multi-purpose service as a failure.

Other aspects of physical change included documentation. These aspects of physical change also held meaning for participants, who expected them to reflect the new model of health service delivery. One registered nurse described confusion when old hospital policies were still being used years after the multi-purpose service had been completed, with no apparent review:

There should be more local policies, nobody makes local policies ... I haven’t ever really been given anything that’s for an MPS, we’ve just been told its area health or its New South Wales Health. I’ve not been told this is a policy that’s been made up for an MPS, I have never seen one. Never (Sue, Staff Member).

When the physical building was complete, planners, architects and builders were described as leaving the site. For many managers and staff members, who were participants in this study, it was when the physical building was complete that they
reclaimed their health service. Mary described how the facility was reorganised to suit their needs:

*Some areas were not going to be utilised as well as they could have been. So we’ve definitely made a mark when we moved in [laughs]. It is the most diplomatic way I can think of, [laughs] of wording it. Yes, things have been re-designated* (Mary, Manager).

Sometimes ‘re-designating’ a space for another purpose, for which it had not been intended, was insufficient and managers were forced to make purchases to overcome problems created by the physical change to their facility. Jane revealed how she organised to buy commodes when she discovered that pre-existing lifters were unable to be used in the new toilets:

*The toilets ... once again it could have been a little bit wider and the toilet a little further away from the walls, because when you come to put people in on lifters; but as I said, we’ve gotten around the problem by having to buy all these commodes. Get them out of bed, get them on commodes and then in here* (Jane, Manager).

Participants also acknowledged that the physical change of co-locating onto a single site was designed to lead to economies of scale which implied economic benefits; for example, buying stock in bulk as patient numbers increased, should have led to reduced prices per patient. However, participants described a reality where health services were often so small that resource shifting was a more accurate interpretation of the integration which took place. For those participants who were involved in a multi-purpose service spread over multiple sites, the benefits available through developing economies of scale were seen as being particularly limited. Being a service industry, the majority of expenditure in health was on staff. Multi-purpose services existing over
multiple sites did not allow the sharing of staff, which would have been their most effective method of achieving savings. Jane, a manager, was one participant who described this situation:

*It was a quick fix, but ultimately down the track a true MPS is actually not what we’ve got and [having multiple sites] does defeat the purpose, because we can’t share staff ... It is still a stand-alone facility* (Jane, Manager).

Participants also suggested that working over more than one site inhibited the ability to integrate. Communication continued to be poor as the effort involved was similar to the effort required when the facilities existed as separate entities, as Jane described in the following excerpt:

*Communication is still not ... as nice or as great as I would like it. Because the thing is you have to physically get out of the chair, get out of the office, go down there [to the hostel site, and] find out what their problems and their issues are. If they were here, you know, it would be just walking down the hall, not a problem* (Jane, Manager).

The property of making physical change encapsulated the material features of the development of the new multi-purpose service. Despite the focus of this property, it also identified the underlying meanings which were attributed by many participants to those material results. As part of the final phase of *collaborating*, the property of making physical change had meaning that related to the degree of integration which took place within the new facility.
6.3.5 Impact of Anticipation of Risk

In the phase collaborating, Anticipation of Risk continued to be the core area of concern for the participants. A new integrated identity was the expected outcome (and final phase) of developing a multi-purpose service as documented in the literature from government sources. Many participants were aware of the expectation of integration and anticipated risks from that outcome. They judged the motives of other stakeholders who were involved in the development of the multi-purpose service and they acted to control the risks they perceived.

When participants judged the motives of other stakeholders to be altruistic they were more likely to trust those stakeholders and to work with them to produce a health service focused on the local community. However, when they judged other stakeholders to be apathetic or motivated by their own self-interest they were less trusting and more likely to work as individuals towards controlling the risks they perceived. Although their close proximity to pre-existing services enhanced their cooperation, participants who were suspicious of other stakeholders were less likely to create an integrated service. During the final phase of collaborating, most participants were neither overly trusting nor overly suspicious.

Trust

Anticipation of Risk in this final phase of collaborating required trust, particularly from those services that handed over their funding and ability to make decisions, in order for the merged health service to integrate into one. Participants described services which
demonstrated features of integration such as shared staffing, staff meeting spontaneously to discuss service provision and identified the service as a multi-purpose service rather than a hospital. Integration was the desired result of the multi-purpose service development; it was what participants had aimed for, as Danielle pointed out:

*What we would really push would be for integration. So people bump into one another in the corridors and have a common dining room and that sort of stuff* (Danielle, Manager).

Participants suggested that in some locations and circumstances integration was clearly evident. At these integrated locations communication between staff, who had previously had little contact with each other, now occurred more effectively. For instance Jenny stated that:

*You’d go to morning tea in the same area and everything, so you’d get lots of inadvertent communication about patients and questions and answers between both sides, because you were just seeing each other more, so that convenience factor improved communication* (Jenny, Staff Member).

Multi-purpose services could also function over more than one site and still manage to benefit from integration. Despite being on a separate site, Helen acknowledged the benefits to clients in this excerpt:

*Oh, it’s great; I don’t have to worry about dragging residents up to the doctor’s or up to the hospital to have bloods taken. [The community nurse] comes down and does all that. If I have a problem she comes down. Dressings we need assessed she’ll come and do that, so whereas before it was just, because we have no hostel car, so before I had to drag residents to the doctor’s and up to the hospital and all over the place ... I [now] have access to a hospital car ... The doctor comes here once a week. Oh, it’s wonderful* (Helen, Manager).
Integration had significant resource implications, mainly related to the workforce. For those multi-purpose services which integrated pre-existing services, employee positions were frequently reduced; for example, one administrative position would be sufficient for both the hostel and the hospital. From some perspective the trust which led to integration had a negative impact as employee positions were reduced. As George pointed out:

*The only thing was that the overnight staff were two, there were upright staff for the hostel, two for the hospital. Now we’ve gone from, those are gone, just two and they can wander through the whole facility* (George, Community Member).

Trust led to integration in this final phase of the basic social process, which had been the aim of developing the multi-purpose service. However, for some sites this led to a reduction in employment opportunities for the community. Some participants described less trusting sites, where suspicion impacted on the degree of integration which was possible.

Suspicion

When participants had come into this final phase of the process of ‘Developing a Collaborative Rural Health Service Identity’, they were committed to becoming a multi-purpose service. Coexistence involved suspicion of others, unlike integration which required trust. For those participants who continued to be suspicious of others in this phase of collaborating, an integrated health service was unlikely. To argue that sites with a high degree of suspicious participants were unsuccessful would be unjustified and overly simplistic. Even at this end of the continuum, multi-purpose services which
were dominated by suspicion had positive outcomes with cooperation between services commonly being described by participants. Also several trusting participants described a need for greater suspicion, and that suspicious participants who frequently spoke of their suspicion were justified in doing so.

Participants noted that cooperation between services involved merely an improved recognition of what other services provided and a desire to work together to meet the health needs of their communities. In some cases moving services onto the same site but not under the same management structure gave the impression of integration without a great deal of change. Coexistence, at the opposite end of the continuum to integration, involved the least amount of collaboration.

Some participants described services (e.g. home care) as ‘cashing out’ with the new multi-purpose service gaining their funding. This often led to the devolution of a community committee and a subsequent loss of status for those members within their community. Some participants described stakeholders who experienced difficulty in ‘letting go’ of their previous role, particularly when ‘their’ service was seen to function less effectively than it had done under their management:

*The committee that used to run the HACC [Home and Community Care] service there, still want to be involved. Still want to be able to manage it and have told the employee, ‘If [area health service] aren’t paying their bills, we want to know about it because we’ll be writing letters,’ ... They just can’t grasp that cashing out means giving management to somebody else. Yeah, they have trouble letting go of a lot of things (Ruth, Manager).*

*Suspicion* was not a purely negative concept. Like coexistence, *suspicion* also had many benefits. Some participants suggested that allowing the pre-existing services to maintain
their own identities often ensured that previous power bases continued. For instance Bev describes that:

_The MPS did all their cooking ... they subcontracted the meals for the hostel. And we had a gate that went through to the hostel, so if they wanted to come in to the doctor, they could just do that easily and we also had a multi-purpose room, which was sort of like a big shed, but it was a proper big room, like a meeting room that they could access from both sides (Bev, Staff Member)._ 

_Suspicion_ was also prevalent in those locations where participants had not wanted initially to become part of the multi-purpose service. Jane described stakeholders from the hostel as being suspicious in this excerpt:

_There’s also still that culture down there of ... us and them especially with the people who resented coming on board (Jane, Manager)._ 

Despite having gone through the development and being gazetted as a multi-purpose service, some participants were unable to identify any change from their previous health service. As Dorothy indicates in this excerpt, little changed in service delivery:

_No, it was just a new building (Dorothy, Community Member)._ 

At one multi-purpose service the ambulance service was relocated into the same building as the acute care and aged care services but there was no integration of services:

_We can make ourselves private by just shutting the door ... Oh, we’re very parochial [laughs]. The mindset you know, sort of we don’t tread on their toes, they don’t tread on ours and it’s because we have two distinct ... employers and two distinct cultures. It is very important to respect the other and not go treading on toes. So sometimes the best way to do that is to stay separate. Good fences build good neighbours [laughs] (Mary, Manager)._
While integration may have been identified as the more desirable option, Danielle points out that coexistence is a good outcome for some communities and may avoid the feeling of participants within some organisations that they have been forced to participate in the development:

There’s lots of scope for all sorts, different sorts of arrangements. I mean you might say well, you know okay it [existing low-care facility] won’t be part of the MPS but you know maybe we can kind of put together some sort of process, so that there’s you know easy movement of clients from low to high or things like that … You know the scope of the model is really up to us and the community and the other stakeholders to work out. It doesn’t always have to be the standard sort of MPS takes over a low-care facility (Danielle, Manager).

Collaborating was the final phase of the process of developing a multi-purpose service although participants still anticipated future change. The dimensions of Anticipation of Risk: trust and suspicion, manifested themselves in the phase of collaboration as integrating (trust) and coexisting (suspicion). The properties of this phase were multi-skilling, developing a new organisational identity, maintaining a hospital identity and making a physical change. Each of these properties could reflect the dimensions, for example, if participants were suspicious of stakeholders they would be unlikely to multi-skill, attempting to isolate their knowledge base for themselves, whereas if they were trusting they could develop new skills providing a greater integration of services.

6.4 Summary

This chapter has described the three phases of the basic social process, ‘Developing a Collaborative Rural Health Service Identity’. These phases of driving change, engaging
with stakeholders and collaborating provided an insight into the experience of participants who were involved in the development of multi-purpose services.

The initial phase of driving change contained the properties of recognising the need for services, economic issues and ownership. Together these properties described the impetus for the development of the multi-purpose service and the issues around decision making in the early planning phase of the development. From this phase came the commitment to the development and entry into the second phase.

The second phase of the basic social process was engaging with stakeholders. This phase contained the properties of being part of a rural community, working with the health service hierarchy, peer support and the time taken. Together these properties described how participants in this study interacted with each other and other stakeholders. How such interactions were negotiated led into the final phase of collaborating.

The final phase of collaborating consisted of four properties: multi-skilling, developing a new organisational identity, maintaining a hospital identity and making physical change. These properties related to the extent to which a new multi-purpose service was developed. Some properties focused on the development of a new identity and the skills to provide that service while others focused on maintaining the pre-existing hospital identity.

Together these three phases make up the basic social process of ‘Developing a Collaborative Rural Health Service Identity’. The following chapter discusses the
substantive grounded theory overall of ‘Developing a Collaborative Rural Health Service Identity’.
CHAPTER 7. DEVELOPING A COLLABORATIVE RURAL HEALTH SERVICE IDENTITY

The purpose of this study was to understand the experiences of participants involved in the development of multi-purpose services. The previous two chapters described the core category *Anticipation of Risk* and the three phases which made up the basic social process. This chapter provides an explanation of the substantive grounded theory, ‘Developing a Collaborative Rural Health Service Identity’, and links together the core category and three phases. This chapter will detail how *Anticipation of Risk* weaves through each of the three phases. Figure 7 below depicts a visual representation of the interaction of the core category *Anticipation of Risk* with each of the phases. The diagram provides an orientation to the discussion which follows beginning with an explanation of the core category.

The data revealed that the central focus of concern for all participants, regardless of whether they were a community member, staff member or manager, was their *Anticipation of Risk*. *Anticipation of Risk* was identified as the core category for the basic social process of ‘Developing a Collaborative Rural Health Service Identity’. Analysis of the data revealed a substantive grounded theory consisting of three phases: *driving change, engaging with stakeholders* and *collaborating*. When small rural health services developed into a multi-purpose service, the participants involved progressed through these three phases. Although systematic, with one phase leading to the next, participants described moving through these phases in a gradual manner rather than
there being a distinct differentiation between each phase. The core category being the central concern of all participants wove through the phases and linked them together.

7.1 Anticipation of Risk

The core category, *Anticipation of Risk*, was interwoven and embedded in each of the three phases (*driving change, engaging with stakeholders* and *collaborating*) of the basic social process of ‘Developing a Collaborative Rural Health Service Identity’. When change occurred in the health service identity, participants anticipated the risk that the change would have on them and the communities they lived in. *Anticipation of*
Risk gave meaning to participant interaction, allowing the interaction to be understood conceptually. This category contained the properties of judging motive and controlling risk and the dimensions of trust and suspicion.

Anticipation of Risk involved a conscious or subconscious deliberation to judge the motives of stakeholders (and other participants in the study) and to control perceived risk. Judging motive allowed participants to decide if other stakeholders were trustworthy or not. Participants wanted to be viewed as altruistic and were more likely to trust other stakeholders when the stakeholders were perceived to be altruistic also. Participants were more likely to be suspicious of other stakeholders when the stakeholders were perceived to be acting in their own interests or to be apathetic.

When participants did not anticipate much risk, they trusted other stakeholders and cultivated the development of the multi-purpose service. When risk was anticipated, participants were suspicious and resisted the development of the multi-purpose service and frequently took action to control it. They would follow this action by again judging motive and then reassessing their need to control risk. Anticipation and control became a juggling act as participants attempted to balance their judgments of motive and attempts to control the risk they anticipated, exerting control or withdrawing it in an attempt to obtain their desired result. This attempt to balance was not always effective. Other participants were frequently aware of strategies to control risk which were implemented and did not always trust the motives behind them.

The dimensions of Anticipation of Risk were trust and suspicion. Trust and suspicion were feelings experienced by participants during their interaction with each other. In the
interactions, many participants did not experience either complete trust or suspicion but seemed to move along that continuum. When participants trusted one another, they developed stronger relationships and were unlikely to question each other’s decisions. When participants were suspicious of each other, their relationships were often superficial and they implemented strategies to control the risks they perceived.

*Trust* and *suspicion*, the dimensions of *Anticipation of Risk*, impacted differently in each of the three phases. *Trust* was frequently the result of local involvement in the initial phase of *driving change*, the influential nature of engagement in the following phase of *engaging with stakeholders* and trust led to *integration* of the health services in the final phase of *collaboration*. In contrast *suspicion* was frequently the result of external involvement in the initial phase of *driving change*, the insignificant nature of engagement in the following phase of *engaging with stakeholders* and suspicion led to *coexistence* of the health services in the final phase of *collaboration*.

In the first phase of *driving change*, *Anticipation of Risk* focused on decision making. Participants judged the motives of other stakeholders (including other participants) by relating to the degree of altruism they displayed. *Suspicion* was often related to decision making which took place externally to the community with many external stakeholders being judged to be motivated by self-interest such as the desire to be perceived as a ‘good’ manager by reducing their budgets. *Trust* was frequently developed locally, where most decision makers framed their motives as being in the community’s best interest. In those communities where decisions were felt by participants to be made locally, *trust* in the development of the multi-purpose service increased. The suggestion
that decisions were made externally to the community increased suspicion among the participants. Suspicion frequently resulted in delays as issues were debated and lobbying of politicians took place.

In the second phase of engaging with stakeholders, Anticipation of Risk continued to impact on the interaction between participants and other stakeholders. Anticipation of Risk was related to the amount of influence participants were perceived to have. Those participants who felt influential within this phase of the process were more likely to trust in people making decisions. At the opposite end of the continuum, those participants who felt that their involvement in this phase was superficial or insignificant developed suspicion.

In the final phase of the process, collaborating, the health service adopted a new model of health service delivery which involved combining existing and additional services. In the final phase, Anticipation of Risk focused on the need to integrate into a single identity. The dimension of trust was related to integration, and suspicion was related to coexistence. Participants suggested that integration with other services was more likely when they trusted other people who were involved in developing the multi-purpose service. If participants were suspicious of the changed model of health service delivery, services merely coexisted.

7.2 Developing a Collaborative Rural Health Service Identity

The core category, Anticipation of Risk, was woven throughout the basic social process. The basic social process was identified as ‘Developing a Collaborative Rural Health Service Identity’. It consisted of three phases: driving change, engaging with
stakeholders and collaborating. Anticipation of Risk provided a link between each of these phases. Figure 7 demonstrates the relationship between these phases and the need for balance between the dimensions of trust and suspicion. A clear boundary was not obvious between each phase. Rather than moving suddenly from one phase to the next, participants moved progressively into the following phase. Each of these phases will be described.

7.2.1 Driving Change

The initial phase of this basic social process was conceptualised as driving change. The process of developing a multi-purpose service did not begin independently or spontaneously. Driving change consisted of the instigation to change the model of health service delivery for a local rural community. This phase described the participants’ awareness of whom or what was driving the initial decisions about whether a small town should develop a multi-purpose service and who should make decisions related to that development. At some locations the multi-purpose service was instigated by community members or the local council, while at others it was the area health service or a State-formed committee (e.g. the NSW Ministerial Advisory Committee on Health Services in Smaller Towns) which instigated the development. The instigators of the development demonstrated their influence early and participants immediately began anticipating the degree of risk associated with them. Conceptually this phase included the properties of recognising the need for services, providing economic funding and ownership.
The core category of *Anticipation of Risk* impacted on the initial phase of *driving change*. Participants judged the motives of other participants on their interaction with the local community. Those stakeholders (and participants) who lived locally and participated voluntarily were judged to be behaving more altruistically than those stakeholders (and participants) who were paid to participate in the process of developing the multi-purpose service. This created a relationship where *trust* was frequently related to local drivers of change and *suspicion* to external drivers.

Participants easily identified local drivers and indicated that they could approach these people and discuss their issues. The accessibility of local people often led to the resolution of problems or an understanding of why compromises were reached. This ability to understand why change was being implemented led to a greater degree of *trust* being formed when drivers were local rather than external. Participants felt that external drivers were imposed upon the local community (‘us’) in a directive manner from sources which were frequently poorly identified (‘them’). ‘They’ usually consisted of government departments, faceless experts, ‘laws’ or ‘regulations’. Rather than identifying external stakeholders, the local community frequently identified the strategies which were being used by external stakeholders to control risk.

The Commonwealth Department of Health and Ageing that controlled the number of aged care beds to be funded within a community was a typical example of an external driver of change. Local drivers of change often involved community lobbying of politicians and the formation of local committees to make decisions related to the development. The nameless and faceless nature of an external driver of change made
‘them’ difficult to be accessed by participants, and written documentation distributed from a distance gave ‘their’ decisions finality, which was difficult to dispute or challenge.

Aged care and community services in particular were often recognised by participants as driving their desire to develop multi-purpose services. Local recognition was described by participants as occurring when people living within the community were active in acknowledging their needs and sought funding to address these needs. External recognition occurred when government departments made funding available to health services based on population numbers and statistics.

Many local communities had begun to address the need for low-care residential aged care facilities in their towns, but had been unable to develop high-care facilities until the multi-purpose service became an option. This ability of the elderly to age within their own community was a common goal for many participants. While participants at several locations embraced the concept of a multi-purpose service, there were some cases where they described government department reports which identified health services to be developed as multi-purpose services. These government departments (i.e. external drivers) were more likely to create suspicion locally when communities interpreted the development as a threat to those services which they already had.

The property of providing economic funding was a significant driver for change. It seemed to function at either end of the core category. Funding could have the impact of increasing trust (local) or suspicion (external). Funds which were raised and distributed by local community members to meet health needs were trusted. At the suspicion end,
both State and Commonwealth Governments (external organisations) provided funding to meet health needs which were deemed important through statistical data and formulas which participants often perceived to be flawed.

In many rural communities health service facilities were old and in need of capital improvement; the enormity of the funding required to address this need was beyond the means of local communities. When the required funding was made available from external (government) sources, the need to improve facilities often led to a willingness within the community to agree to any conditions which may have been attached to that offer. Local participants were unable to identify any other means of attracting the required amounts of funding; they frequently stated that the multi-purpose service development was their only option. Their inability to obtain funding any other way and the extent of their need for that funding drove participants to accept the change offered by the government.

Whoever has ownership of the health service gives that particular stakeholder considerable power in the process of developing their multi-purpose service. Being a public organisation, however, made ownership somewhat ambiguous. The rhetoric of consultation appeared to indicate local ownership, but the reality of decision making maintained government control over health service funding. This contradiction led to a lack of clarity relating to health service ownership.

At the locations participants were recruited from, drivers of change led to a commitment to the multi-purpose service model. Current government and health policy related to this model required the consultation of participants from the community. When change was
driven by local participants, it led to a sense of achievement within the community. Achievement and success enhanced the desire of participants to be involved and encouraged them to trust others who were also involved in the development. Conversely if the main drivers of change were external, participants frequently questioned the trustworthiness and benefit of those drivers to their community. This led to delays and a suspicion that change would be forced upon them.

The degree of trust or suspicion felt by people involved in the first phase is linked to their Anticipation of Risk. When local participants dominated the first phase of driving change, participants were more likely to perceive themselves as influential members of a team, which was working together to produce a desirable change. This led them to engage with each other in a trusting relationship rather than struggling to maintain control of a development that they felt was being forced upon them.

7.2.2 Engaging with Stakeholders

The second phase of ‘Developing a Collaborative Rural Health Service Identity’ was conceptualised as engaging with stakeholders. This phase was dominated by the interaction between the three groups of participants (community members, managers and staff members). In this phase participants were engaged in developing a new model of health service delivery to meet the unique needs of their community. This phase was comprised of four properties: being part of a rural community, working with the health service hierarchy, peer support and the time taken for development.

Participants from each group interacted with each other but, not surprisingly given the size of rural communities, several participants were members of more than one group.
In the following figure (Figure 8), the overlapping circles represent the groups of participants who were interviewed: community members, managers and staff members.

The overlapping circles in the diagram also indicate that different groups were more active at different times of the phase. Community members were more active earlier, as they often instigated this phase and their input was frequently sought in order to ensure that their needs were met in the planning of the new health service. In contrast, the opinions of staff members were rarely sought early in this phase and they became more active towards the end, when they took ownership of the new building and implemented new practices. Managers were most instrumental during the middle portion of the phase; they sometimes felt overlooked during the initial stages of development, but were soon
involved in the planning and, although they developed strategies for new practices, they relied on their staff to implement them, making them less active towards the final aspect of the phase. No group was significantly more powerful or knowledgeable than the others at a local level, but those participants who had been involved in the development of more than one multi-purpose service had a broader knowledge base than other participants.

The core category, *Anticipation of Risk*, impacted on this phase of *engaging with stakeholders*. When participants left the previous phase trusting other stakeholders, they were then more likely to continue to *trust* these stakeholders. *Trust* and *suspicion* were related to whether participants felt their engagement in the process was influential (resulting in and from *trust*) or insignificant (resulting in and from *suspicion*). When they trusted each other, participants were enabled to make decisions increasing their degree of influence. Several participants described situations where consultation had taken place. Frequently, however, these individuals felt that their opinions had been ignored and that the consultation had been superficial. This type of situation destroyed *trust*. When participants did not *trust* each other, they often spent time in lengthy discussions, debates and arguments convincing each other that their own proposals had merit and struggling to increase their ability to influence decision making. Stakeholder groups were substantially committed to the project, so they would be suspicious of the impact of what they considered to be poor decision making on their future work and/or community.
The first property of this phase of *engaging with stakeholders* was ‘being part of a rural community’ and conceptualised the importance participants attributed to being a member of the local community. Managers who were members of local groups (e.g. Country Women’s Association, Rotary) or had relatives who were known and respected within the local community were also better accepted within that community than their counterparts who were not part of that community. Instead the input of managers who were not part of the local community was often perceived as insignificant, and related to minor details rather than significant decisions.

Participants felt that the size of their community impacted on their relationship with government departments. These departments and their representatives were perceived by participants to focus on statistics and economic values which were likely to favour larger communities. Participants feared that their small community was not influential and struggled to overcome this disadvantage. Several communities, for example, criticised the methods used to collect demographic data which they felt portrayed their communities as insignificant.

The health service hierarchy, the second property, was a formalised framework for *engaging with stakeholders* and those people holding positions within it were afforded a measure of *trust* based on their positions within this structure. Participants trusted the hierarchy to appoint suitably qualified and experienced staff to positions within the hierarchy. The obvious hierarchical structure was directly related to the degree of influence held by each incumbent. Those at the top of the hierarchy in positions of senior management were influential; those at the bottom in subordinate roles were
usually insignificant and their opinions were mostly sought in group consultations. According to participants the size of the health service hierarchy created suspicion in smaller services which felt they were being taken over when they merged as part of the multi-purpose service. Participants from small community-owned hostels, for instance, felt some loss of identity when they merged with the much larger area health service. Staff members and managers from smaller services were very aware of how low they would be in the hierarchy when the merger took place. Participants from smaller services also felt the impact of additional layers of management which they saw as inhibiting their ability to provide good quality care.

Peer support, the third property, was particularly important for all three groups of participants. A peer group was described by participants as providing support and information enabling its members to ‘play the system’ thereby improving their ability to influence the process. The assistance gained through the trust of a peer group was particularly important for groups which had little influence. Staff members generally had only superficial or insignificant involvement in the development until this stage. For example some participants who were staff members made contact with trade unions and were able to generate greater influence in decision making. Community members and managers in particular visited other multi-purpose services to get ideas and an understanding of what could be accomplished. Frequently the visits focused on the physical features of the new building, but also included how to deal with other participant groups and how to implement the new model of health service delivery. Peer support and information benefited the multi-purpose services being developed and later
fostered further trust and pride in the participants’ own accomplishments when they were also able to help others to learn from their experiences.

The time taken to complete the multi-purpose service development, the final property, was also a factor in the engagement of stakeholders. Many participants assumed the time taken for the multi-purpose service development to be completed referred only to the physical change being undertaken by the construction companies. When the development took too long, participants felt that consultation was insignificant; decisions were not seen to be the result of consultation as they occurred so long afterwards. When the development was too quick, participants also believed that consultation was insignificant; decisions were perceived to have been made before the results of the consultation could be considered. Although it was difficult to identify an optimal time frame for completion, when a development took too long or was too quick, participants were suspicious of the outcomes. Lengthy developments created fears for job security among staff members, and short time frames were perceived by participants to limit the ability to effectively consult stakeholders.

7.2.3 Collaborating

The final phase in the process of ‘Developing a Collaborative Rural Health Service Identity’ was collaborating. This phase conceptualised the end product: the multi-purpose service. Collaboration referred to the degree to which a multi-purpose service worked together. All multi-purpose services expressed a willingness to collaborate.

In order for services to collaborate as envisioned in government documents as multi-purpose services, staff members and managers needed to accept the challenge of multi-
skilling. Funding for multi-purpose services was almost solely for capital works; ongoing budgets for staffing were rarely increased, so any additional services had to be supplied from existing funds. For existing staff members this required them to develop new skills and to work in additional areas. Attracting new staff had always been problematic and requiring a wider range of skills did not make this easier. When a multi-purpose service was described as being ‘successful’, managers and community members frequently attributed this to the skilled staff members who were employed there.

Forming a new organisational identity, the second property, was expected by State and Commonwealth department policy documents, but was not always embraced ‘on the ground’. Participants did identify that some services took on the new name and established a new integrated identity. Several participants described how the new health service maintained the old identity of a ‘hospital’, merely coexisting with the new services. Some participants identified suspicion which was felt by the community when a name change (from hospital to multi-purpose service) was suggested as they feared the loss of their health service altogether. Many participants continued to use the term ‘hospital’ when referring to the new multi-purpose service. Continuing to use the same language indicated that for these participants little change in culture had taken place.

The core category of Anticipation of Risk remained significant in this phase. Participants would judge each other’s motives to determine the degree of collaboration they wished to engage in, and attempt to control the risks they perceived. When participants were suspicious of the changes their health service was undergoing, they were more likely to
coexist with merging services rather than integrating as one service, as their more
trusting counterparts did. Often the completion of the building was seen to define the
completion of the multi-purpose service development. External people left the
community when the building was completed and this allowed local participants to
regain influence over their health service. Without this focus on physical change, which
had preoccupied participants in the earlier phases, the actual identity and culture of the
new health service became more apparent. The difficulties associated with changing
culture, integrating services and the power relationships which existed, were then
discussed by participants. For some multi-purpose services collaboration did not mean a
great deal of change, as they maintained their ‘hospital’ identity, coexisting with
additional services being provided on site. Some multi-purpose services adopted an
integrated identity with staff becoming multi-skilled and relinquishing their acute care
focus. The dimensions of this phase were related to the extent of collaboration:
integration (resulted from trust) and coexistence (resulted from suspicion).

The dimensions of this phase related to the degree of collaboration which had taken
place and continued to reflect those of the core category Anticipation of Risk. The
dimension of trust involved a sense of integration where participants trusted each other
and worked closely together. The dimension of suspicion involved a sense of
coexistence; participants feared a loss of power and limited their degree of collaboration
to moving onto the one site together. Several participants believed that the pre-existing
health system already consisted of interconnected services which cooperated well
together, therefore there was no need for further integration. Rather than embrace
further collaboration, some of these services merely coexisted. Those health services which functioned over multiple sites had particular difficulty integrating services.

The property of making a physical change provided an indication for participants that the process was complete. For many community members this signalled an end to their role; multi-purpose service advisory committees were dissolved. Some community members stayed on in health council positions. Multi-purpose services were officially gazetted and external influences such as planners and architects withdrew. Some multi-purpose services had been designed over multiple sites. This was usually due to limited funding for capital works which led to the decision to maintain two relatively new buildings, for example, a hospital and a hostel which were not co-located on the one site. The sites in this study were separated by only a few kilometres, but frequently had more difficulty integrating than those which had been designed as a single facility on one site.

7.1 Summary

This chapter has provided an explanation of the substantive grounded theory ‘Developing a Collaborative Rural Health Service Identity’ which emerged from the data. It has identified a three-phased process: driving change, engaging with stakeholders and collaborating.

The core category of Anticipation of Risk connected the three phases and assisted in describing their interaction. Trust was frequently created through the involvement of local people in the initial phase of driving change, allowing participants to influence decision making in the second phase of engaging with stakeholders and was likely to
lead to integration in the last phase of collaboration. In contrast suspicion was frequently created through the involvement of people external to the community in the initial phase of driving change, fuelling the perception by participants that they were insignificant in the second phase of engaging with stakeholders, and was likely to lead to coexistence in the last phase of collaboration. The following chapter discusses the grounded theory ‘Developing a Collaborative Rural Health Service Identity’ in relation to current literature.
CHAPTER 8. DISCUSSION

The purpose of this study was to discover the main concerns of participants involved in the development of multi-purpose services in New South Wales. A substantive grounded theory ‘Developing a Collaborative Rural Health Service Identity’ was constructed from the data; the theory included three phases: driving change, engaging with stakeholders and collaborating. The core category, Anticipation of Risk, impacted on each phase. The grounded theory, the core category and each of the three phases were describing in detail in Chapters Five, Six and Seven.

This chapter will examine the substantive grounded theory and how it contributes to the wider context of research related to organisational change management, community engagement and multi-purpose services. Much of this research lends support for these findings; however, no previous research has identified a theory describing the experiences of people who have been involved in the process of developing a multi-purpose service. This chapter will begin by discussing the basic social process of ‘Developing a Collaborative Rural Health Service Identity’ as a whole, relating it to previous findings in organisational change management. This will be followed by a discussion of how the core category of Anticipation of Risk and the three phases are related to relevant literature.

8.1 Developing a Collaborative Rural Health Service Identity

The substantive grounded theory consisted of three phases: driving change, engaging with stakeholders and collaborating. The data collected from participants in small rural
health services indicates that they progressed through these three phases during the
development of multi-purpose services. This involved both a change in the model of
health service delivery being used by health service organisations as well as a merger of
at least two types of health organisations.

Literature related to multi-purpose services does not discuss in detail how the proposed
model of health service delivery is to be implemented. No research has taken place on
how multi-purpose services have been developed. Due to this lack of research some
comparison is made with literature related to organisational change management.

Lewin (1952, p. 228) in his influential work on organisational change described
unplanned change as continuous and incremental, unlike planned change which he
described in a model with three stages, ‘unfreeze, move and refreeze’. This theoretical
model has been supported more recently in an action research study by Adams and
McNicholas (2007) and specifically in health by Drummond-Hay and Bamford (2009)
in their case study of organisational change in the United Kingdom. Lewin’s model for
planned change has some similarities with the basic social process which emerged from
the data in this study. The initial stage of unfreezing involved the recognition of a need
to change; in the present study this was similar to the initial phase of driving change
which recognised an opportunity for improvement in the current health service. The
second stage of Lewin’s model, moving, involved learning new methods and
overcoming barriers to change. In the present study the second stage was engaging with
stakeholders, which similarly had a focus on implementing change and adapting the
change to the context in which it was being implemented, the rural environment and the
health service hierarchy. Lewin’s final stage of refreezing seeks to stabilise the change and prevent regression to the initial stage. In the current study this stabilisation was seen in some multi-purpose services when participants had developed sufficient trust in the new model of health service delivery and in each other. In those multi-purpose services where sufficient trust was not present, a tendency towards the initial situation could be seen. It is in this final stage of Lewin’s model where the present study adds to current knowledge about organisational change. Rather than accepting the possibility of only two outcomes (the pre-existing situation and the implementation of the planned change), this study suggests that other outcomes are possible. These outcomes are proposed as ranging on a continuum between the two poles of the pre-existing situation and the planned change.

Many participants in this study were recruited from multi-purpose services where a merger of pre-existing services had taken place. The multi-purpose service literature described the purported benefits which are expected from the merger of health services (Sach & Associates, 2000; Hoodless & Evans, 2001). These benefits included strategic fit (Krishnan et al., 1997; Harrison et al., 2001; Larsson & Finkelstein, 2002; Risberg, 2003; McDonald et al., 2005), improved coordination of services (Robinson, 1996; Bojke et al., 2001; Cereste et al., 2003) and economies of scale (Layne, 2000; Bojke et al., 2001; Cereste et al., 2003; Krishnan et al., 2007; Tang & Timmer, 2008). In this study, integration of services was seen in some multi-purpose services. Integration involved a reduction of replication of services and roles and improved communication which are indicative of strategic fit and improved coordination of services. Integration
occurred when trust was demonstrated in the final phase of collaborating. Interestingly in this study participants perceived that economies of scale were one factor which was driving the change for small rural health services to become multi-purpose services. Economies of scale were not described as an outcome. However, the main issue which was identified by participants in this study was related to the core category of Anticipation of Risk.

8.2 Anticipation of Risk

When participants anticipated risk they judged the motives of other participants involved in the process of ‘Developing a Collaborative Rural Health Service Identity’ and they implemented actions to control these perceived risks. Anticipation of Risk was the main area of concern throughout all phases of the process for participants, which warrants examination in relation to current literature.

Management literature often discusses risk assessment. Managers are encouraged to engage in formal judgments related to the possibility of events occurring and the costs those events will have to an organisation (Adler & Kranowitz, 2005; Kytle & Ruggie, 2005; Cotton, 2009; Mendonça & Sapio, 2009; Sympson, 2009). In New South Wales, risk assessment (Workcover NSW, 2001) has been influential in occupational health and safety within health services, so it was not surprising that participants in this study used this term. Grantham (2007) specifically recommended that risk assessment be undertaken by managers early in the process of a merger. However, unlike the formal analysis of possibilities and cost to the organisation which is recommended in management literature (Lawlor, 2002; Bryson, 2003; Adler & Kranowitz, 2005; Kytle
& Ruggie, 2005), this study found that participants used the term more loosely as they informally assessed risks based on a judgment of the motives of other stakeholders involved in the development of the multi-purpose service. Anticipation of Risk was a personal and implicit assessment undertaken not only by managers but also by staff and community members. The difference between managerial risk assessment and Anticipation of Risk may be related to the context in which this research was undertaken. For the participants in this study who were associated with a health service in a small rural community, the risk they anticipated in relation to the health service may have been more personal. Participants described risks related to the health service as being related to the health and wellbeing of close family members. In comparison managers and managerial literature refer to a more abstract business concept, one which does not affect them personally, but rather is related to an impersonal corporate body and fiscal results.

The research provided significant insight into the experiences of participants involved in the development of multi-purpose services. Understanding their Anticipation of Risk which was involved in that development and the significance of this core category to all of the three groups which participated provides a unique insight into the similarities of all participants which has not previously been documented. The conceptualisation of Anticipation of Risk expanded on the current understanding of managers assessing risk. In each of the three phases of the substantive grounded theory, Anticipation of Risk remained the core concern of all participants. Anticipation of Risk included the
properties, judging motive and controlling risk and had the dimensions of *trust* and *suspicion*.

### 8.2.1 Judging Motive

In the present study participants judged the motives of other people involved in the development of the multi-purpose service. The data in this study indicated that more *trust* was attributed to people who were perceived to be motivated through altruism rather than self-interest or apathy. Altruism was considered to be a positive motive when compared with self-interest and apathy.

When participants judged people as being motivated by their own interests, they became suspicious of them. All participants indicated that they were suspicious of people who were motivated by self-interest and such people were described as existing in all groups of participants (community members, managers and staff members). This suspicion slowed the process of the development of the multi-purpose service as participants anticipated greater risks.

Self-interested motives within the context of organisational social responsibility have been previously reported (Ellen, Webb, & Mohr, 2006; Bhattacharya, Korschun, & Sen, 2009). Both these articles describe people who were perceived to have altruistic motives as being trusted to a greater extent than those people who were perceived to be motivated by self-interest. The importance of judging motive in the determination of the degree of *trust* or *suspicion* which participants felt towards other people in this study supported this literature. Clearly judging motive contributes to the understanding of
how *trust* was developed in the implementation of organisational change in the context of multi-purpose service development.

### 8.2.2 Controlling Risk

During health mergers managers were expected to manage risks (Adler & Kranowitz, 2005; Kytle & Ruggie, 2005; Cotton, 2009; Mendonça & Sapio, 2009; Sympson, 2009). Engaging experts to manage or control risk (e.g. financial, architectural) was a common strategy used during the development of multi-purpose services (Andrews et al., 1995; Sach & Associates, 2000). In anticipation of unforeseen risk experts were engaged to provide advice about how risk could be avoided or managed. This study found that expert knowledge was commonly sought from outsiders (experts) during the development of multi-purpose services but that local people perceived that expert knowledge was privileged above their local knowledge. This finding was supported by Lahiri-Dutt (2004) in their case study of community engagement in a transport development in New South Wales.

As the objectives of the multi-purpose service model were very general (to provide a wide variety of integrated health services), relying on expert knowledge which has a narrow and specific nature was problematic. The design of multi-purpose services as integrating a variety of health services requires expertise not only in each of those health services but also in how they can best be combined. The desire to meet community needs results in a unique combination of health services within each multi-purpose service, creating unique issues for each multi-purpose service. Participants described
these unique features as making it difficult to become an expert in multi-purpose services and requiring greater value to be placed on the expertise of local stakeholders.

8.2.3 Trust

In this study Anticipation of Risk was conceptualised as having the dimensions of trust and suspicion. These dimensions contribute to the knowledge about organisational change management by linking literature on trust and suspicion to change management.

In this study trust implied vulnerability, a risk of losing something which was valuable; this definition is consistent with the literature (Parkhe, 1998; Dietz & Den Hartog, 2006; Cvetkovich & Nakayachi, 2007; Chryssochoidis, Strada, & Krystallis, 2009; Clouder, 2009). The factors of trust initially described by Mayer, Davis and Schoorman (1995) include integrity, ability and benevolence, and continue to influence research (Burton, Lauridsen, & Obel, 2004; Adler & Kranowitz, 2005; Braithwaite, Iedema, & Jorm, 2007; Laine, 2008). Integrity was described as a set of principles acceptable to the trustor (Mayer et al., 1995). As these factors were not sought within the data, it was not a great surprise that integrity did not emerge as being significant to participants. It is possible that they did not distinguish it from trust – as it is difficult to trust someone without integrity.

As a factor in trust, ability involves skills, competence and characteristics which enable influence in a contextual domain. Perception of ability involves an assessment of that ability together with expectations of what will need to be accomplished (Mayer et al., 1995; Chryssochoidis et al., 2009). In this study ability was described as expert
knowledge (see Section 5.2.1) and was a strategy used to control risk. Despite participants in this study confirming the need to assess the ability of others involved in the development before trusting them, they did not place great value on formal qualifications or hierarchical positions within the organisation. Participants preferred to judge ability based on outcomes, perceiving people to have ability if they were successful in achieving desired results.

Benevolence as a factor of trust was defined as “a positive orientation of the trustee toward the trustor” (Mayer et al., 1995, p. 719). The factor of ‘benevolence’ was similar to the ‘altruism’ which participants in this study described as increasing their trust in others. Whereas benevolence indicated that the ‘trustor’ may gain from the relationship, participants in this study did not perceive themselves as needing the health care services which were the focus of the multi-purpose service development. For that reason, altruism may have been substituted for benevolence as a positive orientation towards other people in general. For participants in this study, altruism was a more significant factor than ability or integrity in increasing their trust in others. Participants frequently commented on their own altruistic behaviours which demonstrated the value they placed upon this quality in others.

Trust was also frequently mentioned in the literature related to social capital, with one author going so far as to define social capital as trust (Rothstein & Stolle, 2007). The term social capital implies that concepts of capital, which were merely focused on economics, were incomplete (Maloney, Smith, & Stoker, 2000; Pope, 2002; Ziersch, Baum, MacDougall, & Putland, 2005; McGonigal et al., 2007). Several authors
(Astone, Nathanson, Schoen, & Kim, 1999; Maloney et al., 2000; McGonigal et al., 2007; Dolfsma, Eijk, & Jolink, 2009) identified trust, altruism, generosity, obligation, participation and reciprocity as building social capital. However, Woolcock (1998) in his early work on social capital, particularly warned against confusing the consequences of social capital, such as trust, with social capital itself as he felt trust indicated the presence of social capital rather than creating it. In the present study altruism was linked to trust, with perceptions of altruism increasing the degree of trust participants experienced; but of all the components of social capital, trust was the one which was identified to be of interest to participants in this study (Anderson et al., 2009). Despite some mention of generosity, obligation, participation and reciprocity by individual participants in this study (see Being Part of a Rural Community, Section 6.2.1), these factors did not appear with enough frequency in the data to be considered significant. Social capital also did not emerge as being significant to participants in the present study.

Social capital also has been described as having some negative consequences. Major criticisms of social capital include it having led to the exclusion of people outside the local network (Putnam, 1993; Cuthill, 2003) or that it reinforced social inequalities (Osborne, Baum, & Ziersch, 2009). Maloney et al. (2000) discussed the exclusionary practices of groups where professionalisation led to a closure of social networks to prevent people who did not meet professional criteria from being accepted within that group. They indicated that these practices lead to greater social capital for the members of those groups creating trusting relationships between group members, which are not
available to ‘outsiders’. Rural communities also were perceived to be high in social capital (Ziersch, Baum, Darmawan, Kavanagh, & Bentley, 2009). In his early work, Portes (1998) linked the concept of social capital to being part of a small community, referring particularly to the ease and efficiency of communication among community members which implicitly restricted those who were outsiders. Some of these negative consequences of social capital were also apparent in this study where features of exclusion were apparent, such as the valuing of expert opinion over those of community members and the suspicion (see Suspicion in Section 6.1.4) which participants attributed to those stakeholders who were external to their community.

Another discussion about social capital sees it in terms of connections between groups. The need for an ‘optimal configuration’ of connections is described as a combination of tight and loose connections, which indicates that there are benefits to both types. An optimal configuration would enhance group cohesiveness (with benefits of improved workload sharing, open communication and supportiveness) but allow the formation of relationships outside the group (with benefits of improved resource flows and understanding of the activities of other groups) (Hongseok, Labianca, & Myung-Ho, 2006). This indicates the need for balance, which is a concept put forward in this study also – a balance of trust and suspicion. In the present study trust was frequently assigned to those stakeholders who were local members of the community, but they alone were unable to develop the multi-purpose service. Relationships with people external to the community were also required. Despite their suspicion of external
stakeholders these people provided not only funding, but also valuable ideas on how best to create a multi-purpose service.

In the literature related to multi-purpose services, trust was not discussed in great detail, but this could be related to the general paucity of literature which was found. No mention was made of how to build trust, although there was brief mention of the benefits which would ensue (National Rural Health Alliance, 1996) and the possibility of breaking trust (Evans et al., 2006). Trust was a significant dimension for the basic social process which emerged from this research, suggesting that it was important to participants. The participants in this study have provided unique information about how trust was developed and how it impacted on the process.

When trust was felt by participants, they reported that the development of the multi-purpose service moved forward at a faster pace. The faster pace seemed to occur due to the limited need to discuss decisions and to convince others of the value of these decisions. For instance Danielle described a situation where the project team quickly reached consensus due to the trust they had in each other (see Trust, Section 5.3). Limiting discussion sometimes resulted in single opinions dominating. In the example provided in the section on expert knowledge (Section 5.2.1) where an expert was trusted to provide suitable suction equipment, a misunderstanding occurred due to a lack of discussion which resulted from trusting that the expert understood the request. Participants in this study reinforced the notion that trust was positive and suspicion was negative in their statements. However, this was simplistic and sometimes incorrect. Not
only was suspicion justified at times, but a healthy degree of suspicion ensured diverse opinions were heard and could lead to the development of unique solutions.

8.2.4 Suspicion

Existing literature clearly describes trust as a positive attribute. The National Rural Health Alliance (1996, p. 5) specifically states that multi-purpose services “require a substantial amount of trust”. This study refutes that assumption indicating that both trust and suspicion seemed to contribute to producing a collaborative and integrated new health service identity. Too much trust provided opportunities for misunderstanding and enhanced the speed at which the development occurred, inhibiting the ability of stakeholders to identify or rectify misunderstandings. A healthy degree of suspicion on the other hand promoted discussion and consideration of alternatives.

Groups which demonstrate strong cohesive links between group members are described as having issues related to decision making. Strong group cohesion leads to concurrence seeking behaviour, where group members are inclined to agree, rather than disagree with the group. This phenomenon has been labelled ‘groupthink’ (Baron, 2005; Henningsen, Henningsen, Eden, & Cruz, 2006; Klein & Stern, 2009). ‘Groupthink’ has distinct similarities with the perceptions of participants in this study when they described an imbalance resulting from too much trust in others who were involved in the development of the multi-purpose service (see Section 5.3).

Mayer et al. (1995) in their early work on trust suggested that a lack of trust would lead to greater surveillance or monitoring of others; this has similarities with the concept of
suspicion in this study as existing at the opposite end of a continuum to trust. Suspicion involved a lack of trust or a belief that another person may act in a malevolent manner towards them. When participants were suspicious they would monitor other people’s behaviours with the aim of controlling the risks they anticipated.

Suspicion has been poorly documented, particularly in relation to the development of multi-purpose services. Suspicion was described as existing in communities with a history of reductions in health services prior to the development beginning (Keating & Calder, 1997; Evans et al., 2006). Benefits of suspicion however, were not documented. The participants in this study were able to provide examples from their experiences where suspicion was beneficial, showing how it allowed them to intervene to prevent further reductions in services or to consider a variety of solutions.

This study found that encouraging a healthy degree of suspicion may overcome issues of concurrence in group decision making. Balancing trust and suspicion allowed effective involvement and open discussion which ensured that issues were recognised and could be addressed.

8.3 Driving Change

The initial phase of the process of ‘Developing a Collaborative Rural Health Service Identity’ was that of driving change. This study found that there were several drivers of change in the process of developing a collaborative rural health service identity. They were recognising the need for services, economic issues and ownership. The drivers were influenced by the core category of Anticipation of Risk.
When participants anticipated risks they were more likely to trust change if it was one driven by local community members; and participants were more suspicious of change when it was imposed from an external source. Those people who were local drivers of change were often described as having a shared history with and being easily accessible to local participants in this study. In contrast people who were external drivers of change had little or no shared history and were more difficult to contact if issues arose.

Some research studies (Davies et al., 2000; Fraser, Dougill, Mabee, Reed, & McAlpine, 2006) confirm the theories found in the change management literature (Woolcock, 1998; Brown, 2008) that identified the need for both top-down (external) and bottom-up (local) efforts, which are dynamic and combine to produce positive outcomes of change within communities. Other authors (Durey & Lockhart, 2004; Fulop et al., 2005; Brown, 2008) indicated that change would not be accepted (trusted) by the community if it only came from external sources, due to community perceptions of the importance of local knowledge and capacity. Those rural communities described by participants in this study which lobbied for the development of a multi-purpose service at an early stage (i.e. bottom-up efforts), were able to establish the value and strategic importance of their role early in the development of the multi-purpose service (Anderson et al., 2009). In addition, this study found that participants who were more trusting of bottom-up (local) change efforts still identified that assistance was also required from top-down (external) change efforts in order for the new service to succeed. Such a combination of bottom-up and top-down efforts would assist in planning a change that would meet local needs in the most effective manner. The present study expands the understanding of
by describing it from the perspective of participants who are engaged in a change process, rather than managers implementing organisational change. What follows is an exploration of the properties of driving change which were found in this study.

8.3.1 Recognising the Need for Services

The service need that was recognised by most participants was that of aged care services; it was acknowledged to be a major outcome of multi-purpose services (Andrews et al., 1995; Sach & Associates, 2000; Hoodless & Evans, 2001; Roberts & Thompson, 2003; NSW Health Department, 2005). Many of the small rural communities where participants in this study were located did not have nursing home (high-level care) facilities. Participants indicated that not only were aged care services an important need for their communities, but they also improved markedly with the new multi-purpose service (see Recognising the Need for Services, Section 6.1.1).

Despite the well received benefit of aged care services, many participants described a rhetoric of ‘recognising the need for services’ which resulted in the replacement of acute care services with a greater variety of, but in total less expensive, visiting services. The early suspicions participants had of acute care bed numbers being reduced were frequently perceived to have been well founded.

Those communities which were fortunate enough to have people with strong voices to ‘fight’ on their behalf were able to attract greater resources than other communities. Despite community consultation being viewed by the Australian Government as
extremely important in both the development and ongoing management of multi-purpose services (Hoodless & Evans, 2001; James, 2001; Neumayer et al., 2003; Tonna & Lander, 2003; Australian Government Department of Health and Ageing, 2004; Australian Health Ministers’ Conference, 1994), there is little documentation of how community consultation should be managed. The managers and staff members involved in the current study were accepting of what was offered to them by their health service hierarchy and were particularly reliant on community members to attract greater resources. Those communities which did not have such vocal or well connected community members accepted what they were offered. Recently the Federal government’s imperative that multi-purpose services should meet the unique requirements of each community (National Health and Hospitals Reform Commission, 2009) has raised the importance and requirement for rural communities to have the ability to vocalise local health care needs.

Integrating pre-existing aged care facilities with the new multi-purpose service was perceived as controversial by several participants. The early New South Wales policy of mandatory integration of existing hostels into the new multi-purpose service has been reviewed to increase its flexibility, with the new policy no longer precluding the development of a multi-purpose service if the hostel does not wish to participate (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000). There was little documentation about why this policy was altered, but several participants in this study described the effects of the early policy as creating suspicion. Participants
indicated that the increased flexibility of the new policy could reap benefits by increasing trust with stakeholders (see Suspicion, Section 5.4).

The perception of what services were required was different for community members than for other participants in this study. Community members, who were participants, continued to remember previous service provision as having been successful and hoped for a return of those services, including obstetric and surgical services. Previous literature supports this finding. Health and services are viewed by communities as assets, and threats to their viability were seen to undermine the viability of the community itself (Halseth & Ryser, 2006; Kearns, Lewis, McCreanor, & Witten, 2009). In addition it has been widely reported that Australian rural communities are concerned about the withdrawal of rural obstetric services which has increased the financial and socio-cultural burdens due to having to travel long distances to access these services (Roach & Downes, 2007; Dietsch, Davies, Shackleton, Alston, & McLeod, 2008).

Allan, Ball, Alston, and Alston (2007) indicated that the needs which are expressed by communities are unreliable; they only recognise the ‘services that exist or recently existed’, rather than the ones required by the community. The present study confirms that some of the needs expressed by communities can be defined in this way, with participants in this study expressing the need for surgical and obstetric services which previously existed. However, other needs expressed by participants in this study contradict those findings, such as the need for nursing home services which were widely identified by participants and had never been available in these communities. These findings suggest that communities are able to express the need for services which they
have not had previously, and further research should be undertaken to determine how communities determine their health service requirements.

8.3.2 Economic Issues

In rural Australia the replacement of policies of equity and access to services with policies of economic efficiency has led to the decline of commercial and public services (Alston, 2002; Larson, 2002; Brett, 2007; Hall & Michael, 2007). Australian rural communities have been suspicious about economic rationalism which they perceive as a reduction of facilities (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Durey & Lockhart, 2004; Evans et al., 2006). This study reinforces these suspicions. Participants indicated that their memories were longer than those of government departments and many participants had already experienced reduced health services. This led participants to be suspicious about the motives of the government when a multi-purpose service was proposed.

Economic issues were found to be significant in driving change in this study. Participants reported the need for additional funding for their local health service and that there were limited options available to secure funding. Participants, regardless of whether they were health managers, staff or community members, were aware of the economic constraints faced by health services and they could see (and experience) the poor health status of rural Australia as was also in the current literature (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; Australian Institute of Health and Welfare, 2005; Greater Western Area Health Service, 2007; Independent Pricing and Regulatory Tribunal, 2008; Wakerman & Humphreys, 2008).
Participants in this study suggested that government departments planning to develop multi-purpose services frequently questioned the viability of small rural hospitals. The literature related to rural health also suggests that developing multi-purpose services provide a secure future health service for communities which would otherwise be unable to sustain them (Snowball, 1994; Bailey, 1995; Mensink, 1995; Duffy, 1997; Evans et al., 2006). Strasser et al. (1994, p. 11) describe the local hospital as “part of the economic and social fabric of the community” which they feel leads to strong resistance to any rationalisation of services. More recently, Evans et al. (2006) describe the link between the loss of acute services and an inability to attract and maintain businesses and residents in small rural communities. As Strasser et al. (1994) point out, the local rural hospital is often the major employer within a town and a regular purchaser of goods and services. Many participants were aware of the positive impact that funding for a multi-purpose service could have on the economy of the entire town. This included the long-term purchase of goods and services and also the employment of a substantial workforce from the community. Any possibility of reducing bed numbers (and by implication staff numbers) was perceived by some participants as threatening the sustainability of their community.

Evans et al. (2006) point out that the Multi-purpose Service Program was introduced during a time of sweeping economic health reforms by Commonwealth and State Governments, which aimed to improve efficiency in health care services. Acute health services required an overwhelming majority of the limited available health budget, and senior health managers were not overly interested in small rural health services or the
Multi-purpose Service Program (Evans et al., 2006). This study is consistent with the sentiment described by Evans et al. (2006); participants frequently indicated that the small size of their community or health service impacted on their ability to influence decision makers.

8.3.3 Ownership

For over a decade rural health groups and health reports have suggested fostering “a sense of community ownership of new or changed local health services” (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000, p. 27) and have called for giving control and ownership of multi-purpose services to local agencies (National Rural Health Alliance, 1996) in order to engage with and reassure communities that their opinions are valued.

In the only national evaluation of multi-purpose services undertaken, Andrews et al. (1995) stated that state-wide differences in administration of multi-purpose services had an impact on the options which were available in each State. In Victoria the Department of Human Services (1996a) recommended that the management body of a multi-purpose service should be independent from Commonwealth and State Departments and be representative of the community. In contrast Mott et al. (1995, p. 6), in discussing the situation in Western Australia, stated that “The State has negotiated that accountability will be through State Health Authorities”.

Nicoll et al. (2004) in their audit of the role of the Commonwealth in the Multi-purpose Service Program (which provides funding for the development of multi-purpose
services) acknowledged that the Commonwealth and State Governments are required to cooperate in selecting and funding suitable multi-purpose services. Although this is one way for suitable locations to be identified, they also stated that ‘self-identification’ by the community was appropriate. In the present study some participants spoke about communities which had taken advantage of this ability to ‘self-identify’. Participant data suggests that these communities perceived a greater ownership and trust in the resultant multi-purpose service. Participants described other communities as being suspicious when the multi-purpose service was instigated by government departments. This confirms the position described by the National Rural Health Alliance (1996) where some local government authorities feared a ‘loss of local control’ when developing a multi-purpose service and celebrated their ‘reprieve’ if they were removed from the list of sites ‘targeted’ for development as multi-purpose services (National Rural Health Alliance, 1996, p. 16).

Negotiations for local facilities to be taken over as multi-purpose services at peppercorn rent were rarely mentioned in the literature. Mills (1995, p. 232) describes one such situation in Western Australia, where some people interpreted this as ‘a government take-over’. This study adds to the literature by describing how participants interpret peppercorn rentals as an acknowledgment not only of previous ownership of the facility involved, but also as a lack of current ownership. This initial phase of driving change was followed by one of engaging with stakeholders.
8.4 Engaging with Stakeholders

The phase *engaging with stakeholders* encapsulated the relationship between participants and stakeholders as it described the separate but also overlapping roles of community members, managers and staff members and their interaction with each other.

In the literature related to community engagement, learning about the background of a community is seen to be an effective way to build *trust* (La Porte & Metlay, 1996; Adler & Kranowitz, 2005). Dunn (1995) and Humphreys et al. (1996) suggest that previous experiences of cooperation or tension between organisations impact on the process of developing new multi-purpose services. The current study reinforces the view that the trustworthiness of individuals (or groups) is assessed by looking back at their previous behaviour. In order to develop trust people need to have repeated interactions with each other. This gradually forms a reputation, but one that can be destroyed quickly (Dasgupta, 1990; Mayer et al., 1995). In this *engaging with stakeholders* phase, mutual background was significant in building *trust*; participants were more likely to *trust* those stakeholders who they had been involved with previously, than stakeholders who were not part of their normal networks.

8.4.1 Being Part of a Rural Community

Rather than merely describing a relationship with the community, staff members who were participants in this study indicated that they lived in the community, had relatives who were community members and felt that they were also part of the community. The findings from this study expand the existing literature of the close relationship of rural
health staff with a community. This close relationship has been described in previous research into rural health services as either the most rewarding or most frustrating feature of their work (Hegney, 1996; Farmer, Lauder, Richards, & Sharkey, 2003; Mills, Francis, & Bonner, 2007; Allan, Ball, Alston, & Alston, 2008).

In this study most participants identified with living in a rural community and valued their sense of being part of a small community. Despite some community members expressing the opinion that employees of the health service were too closely linked to and identified with the health service, staff members and managers expressed frustration when they were excluded from parts of the process of developing the multi-purpose service. The majority of staff members and managers also lived within the community and felt they were part of that community despite being treated differently to other community members.

Community engagement has been seen as important in both the development and ongoing management of multi-purpose services by many Australian government bodies (Australian Health Ministers’ Conference, 1994; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000; National Rural Health Policy Subcommittee & National Rural Health Alliance, 2002; Department of Health and Ageing, 2004). The Victorian Department of Human Services and Department of Health and Ageing (2003, p. 7) states that “community consultation and participation is vital to the service planning process”. They specify that each multi-purpose service should develop a consultation strategy which specifies not only who is to be consulted but why and what the intended outcome would be. The degree of community engagement which
was described in this study varied depending on the multi-purpose service where the participant was located.

Several participants in this study judged community members to be apathetic about decisions related to their multi-purpose service, which is confirmed by Andrews et al. (1995) who agree that it is only when community members have a need for services that they take an interest in what is available. However, others (Strasser et al., 1994; Keating & Calder, 1997) identify communities as wanting local participation in the planning and implementation of multi-purpose services in order to protect and preserve their community and its assets. Another perspective found in the more general community engagement literature, was that engaging with community leaders or representatives did not ensure that communities felt engaged (Blake et al., 2008; Hoodless, Bourke, & Evans, 2008). In this study it was also apparent that several community members wanted to participate, even though others were perceived to be apathetic. This apparent contradiction demonstrates the diversity of interest in community engagement within small rural communities.

Consultation was a time consuming, complicated and expensive process (Keating & Calder, 1997; Evans, Hoodless, Flanagan, George, & Hazeleger, 2002; Fraser et al., 2006; Hoodless et al., 2008). Current health and government policy encouraged the involvement of community members in the development of multi-purpose services (James, 2001; Neumayer et al., 2003; Tonna & Lander, 2003; Department of Health and Ageing, 2004, 2008) which implied a degree of trust in the ability of the community to meet its own needs and improve the quality of the health care being provided (Bell,
Brown, & Morris, 1995; Evans et al., 2002). Despite this implication of trust, community knowledge was questioned with suggestions that public ignorance about health and the health care system should indicate caution when giving community members an active role in decision making (Chapman, 2000; Evans et al., 2002; Durey & Lockhart, 2004; Brown, 2008; Garling, 2008).

Frequently information is required by communities in order for them to participate effectively in consultation. However, providing information should assist communities to make a considered judgment and/or contribution, not to convince them of predetermined decisions (La Porte & Metlay, 1996; Bidwell, 2001; Adler & Kranowitz, 2005; Fraser et al., 2006; Brown, 2008). Durey and Lockhart (2004) in their study of two multi-purpose service developments in Western Australia describe the confusion which resulted when community meetings about multi-purpose service development were used to both consult with the community and to educate them simultaneously.

This study confirms that combining community information and consultation sessions into one event was perceived by participants as being manipulative. Participants indicated that this was designed to convince them that the community had been involved in a decision making process, although they had not actually been given a choice. Participants frequently acknowledged a suspicion that ‘their’ health service would not receive the funding it required to continue to operate if they did not accept the new multi-purpose service model of health service delivery. This fundamental lack of choice was perceived by many participants as directly contradicting the rhetoric of
consultation. Participants described a lack of choice as inhibiting their ability to trust in consultation when they perceived the results of the consultation were pre-determined.

Several authors (Bidwell, 2001; Brown & Keast, 2003; Durey & Lockhart, 2004; Fraser et al., 2006) confirmed this cynical view of participants that seeking local community input was designed to generate community support or decrease their dissatisfaction, rather than increasing their satisfaction. Involving the community without the intention of listening to them frequently angered them (Adler & Kranowitz, 2005; Fraser et al., 2006). Sullivan et al. (2001, p. 136) indicated that such superficial consultation may be related to power imbalances, describing a case study where the critical factor was identified as who made funding decisions. However, Jonker and Foster (2002) pointed out many stakeholder groups were quite sophisticated and aware that organisations attempt to manipulate them. It was this cynical view, that community consultation was more superficial than government policy rhetoric would suggest, which was supported in this study (Anderson et al., 2009), and participants frequently identified that they felt manipulated by the consultation which did take place.

In their case study of the development of a multi-purpose service in Western Australia, Durey and Lockhart (2004) describe managers involved in the development as being under the assumption that the multi-purpose service was the only option available for the community to maintain its services. This type of belief may have inhibited their ability to provide their community with other options when assessing community needs, and was strongly reinforced by managers involved in the present study who also believed a multi-purpose service was the only option available.
For managers being part of a rural community was also significant in the differences it created between themselves and the health service hierarchy. Some management literature mentions benefits related to building trust which arise from organisational leaders maintaining a visible and accessible presence in their communities. When these organisational leaders hold significant positions, their presence indicates the value which is placed on the community by the organisation (La Porte & Metlay, 1996; Marshall, 2009). This was confirmed in this study where the involvement of government officials and senior managers from the area health service was appreciated by all participants.

Similarly, this study also found that the prominence within the local community of the health service manager impacted on the community’s trust of that manager. Both the change management and community engagement literature overlook the importance and role of health managers being part of rural communities, although Lewis (2004) describes the health service manager as public property, as the face of a rural health service. In this study it was found that having a manager who lived locally and participated in community groups (e.g. Lions, Rotary, Country Women’s Association) made them more accessible to community members and inspired greater trust within that community. For those managers who were attempting to manage more than one site, this was a particular problem and one which many participants felt was not well acknowledged by bureaucrats in government departments.
8.4.2 Working with the Health Service Hierarchy

In 2003 the majority of funding for multi-purpose services was provided by the State Governments (Nicoll et al., 2004). The power associated with this funding ensured that the State-funded health services could maintain their control of the newly developed facilities if they desired, and in all the multi-purpose services included in this study that was the case. For all the participants this meant they were required to work with the health service hierarchy.

This study did not specifically study the role of managers in creating change, but did reveal their perspectives of the change required to develop a multi-purpose service. The study also revealed the perspectives of other participants (staff members and community members) who were involved and indicated that they all had a similar experience.

The health service managers who participated in this study perceived themselves as having no more control over what was happening in their health service than other participants. This was consistent with some management literature which indicated that organisational hierarchies create such situations where middle managers have little power by centralising management and removing autonomy from operational managers. This frequently left middle managers feeling underestimated, describing change as being imposed upon them and having limited ability to influence decisions and outcomes (Greenhill, 2006; Kavanagh & Ashkanasy, 2006; Skela Savič & Pagon, 2008a; Marshall, 2009; McGurk, 2009). In contrast, an earlier study by Floyd and Wooldridge (1992) described middle managers as having the role of ‘linking pin’ in the organisation, coordinating top and operating level activities, by championing
alternatives, facilitating adaptability, synthesising information and implementing deliberate strategies. This role was apparent in the data collected about health service managers in this study. However, participants who were health service managers perceived this to be their usual role, rather than a role specifically related to the development of the multi-purpose service.

The perception of participants in this study, that local managers had little control over the change process, was linked to the limited and/or conflicting information they received about budgets, equipment and staffing (see Section 6.2.2) related to the development of the multi-purpose service. Access to information can be viewed as empowering individuals within an organisation, allowing them to see the ‘big picture’ and helping them determine how their role impacts on the organisation (Spreitzer, 1996; Moynihan & Pandey, 2003; Thorpe & Loo, 2003). In this study, managers who had been involved in the development of more than one multi-purpose service found that access to information was improved as they had a greater understanding of the people and resources they could access for assistance. The combination of limited decision making power and poor access to information left health service managers who participated in this study feeling that the resultant organisational culture was not within their control and thereby not their responsibility.

8.4.3 Peer Support

Participants in this study found the support of their peers to be an invaluable learning tool. This has also been recognised in other studies related to multi-purpose services (Andrews et al., 1995; Humphreys et al., 1996) and is further supported by
recommendations which suggest the development of formal support mechanisms. Andrews et al. (1995) recommended that a coordinated set of guidelines and materials be made available nationally and the provision of funding for more experienced multi-purpose services to provide an advisory role. Hall and Medley (2001) described the benefits of quarterly newsletters, a web page and network forums held in Western Australia for multi-purpose services and prospective multi-purpose services. Eccles (2002) and Gibb, Anderson and Forsyth (2004) suggested a mentoring scheme and the Victorian Department of Human Services and Department of Health and Ageing (2003) encouraged benchmarking with other multi-purpose services to enable continuous improvement. Despite the clear acknowledgment within the literature of the benefits of peer support, few participants described formal support mechanisms being in place when they were involved in developing multi-purpose services. Instead the experiences of participants involved in early (1998) multi-purpose service developments was remarkably similar to those participants involved in later (2003) developments, which indicated that learning from peers was limited.

8.4.4 Time Taken

In this study participants described the time taken to complete the development of the multi-purpose service as lengthy. Participants perceived this as being necessary to ensure that adequate consultation took place.

Despite indicating that the process of developing a multi-purpose service would be a lengthy process, participants noted that the time taken created issues related to the continuity of managers and the need to reassure stakeholders who had not expected it to
take so long. The literature related to multi-purpose services stresses negative aspects of prolonged developments, such as difficulty sustaining enthusiasm for and commitment to the implementation of the multi-purpose service model when it does not follow soon after consultation (Andrews et al., 1995; Keating & Calder, 1997).

In contrast literature related to building trust in organisational mergers stressed this was a lengthy process (Parkhe, 1998). Others indicate that incremental change produced better results than rapid change (Greenhill, 2006; Kavanagh & Ashkanasy, 2006; Boss, Dunford, Boss, & McConkie, 2009; Greasley et al., 2009) and suggest that too short a time frame creates uncertainty and erodes organisational identity (Ullrich et al., 2005). Additionally the benefits of a courtship period which allows relationships to develop between two merging organisations are also described (Lodorfos & Boateng, 2006; Gomes et al., 2007). The participants in the present study confirmed the need for a lengthy process to develop multi-purpose services effectively and also identified the benefits of a ‘courtship’ period when mergers were proposed.

8.5 Collaborating

Collaborating was the final phase in ‘Developing a Collaborative Rural Health Service Delivery’. Collaborating describes how participants experienced the collaboration which occurred between the amalgamated services which had become the multi-purpose service. Anticipation of Risk continued to be a core concern of participants. When participants described stakeholders as trusting one another, they were more likely to develop a new integrated health service than if they were described as being suspicious
of one another, which was more likely to lead them to develop a cooperative relationship.

Different degrees of integration were described in the management literature as having different benefits, with successful integration depending on the result which was desired. For short-term relationships with limited resources, lower levels of integration were desirable; in comparison long-term relationships which focused on a common mission and required greater resources, greater levels of integration were desired (Brown & Keast, 2003; McDonald et al., 2007; Brown, 2008). This literature recognised that all forms of integration were useful. Low levels of integration were not a bad or unusual feature of health organisations (Davies et al., 2000). In this study low levels of integration were described as coexisting. Despite coexistence not being a stated objective of a multi-purpose service, it was not interpreted as a negative outcome by participants.

Coexistence could lead to greater recognition of the differences which the pre-existing organisations brought to the new organisation and was described in a positive light in the literature related to global mergers where cultural differences were considerable (Janssens & Brett, 2006; Shokef & Erez, 2006). In an organisation where a balance exists between trust and suspicion, coexistence could assist to overcome issues of concurrence within an organisation. For those organisations which were attempting to combine dissimilar cultural groups which were functioning effectively prior to merging, coexistence could be beneficial. Some participants indicated that the multi-purpose
service could function effectively even if pre-existing organisations maintained some independence within the new service.

Coexistence did not entail as great a risk for pre-existing organisations when merging as integration would do (Mayer et al., 1995). Small companies in particular were naturally more vulnerable when merging with larger companies (Parkhe, 1998). This required greater degrees of trust from the smaller company if integration was to occur. It should not be overlooked that in some cases such trust was misplaced, making a coexisting identity a better solution than an integrated one (Parkhe, 1998). The size of the State-funded area health service which assumed management of the multi-purpose service was much larger than any community-managed service which was given the opportunity to ‘come on board’ with the proposed model of health service delivery (see Collaborating, Section 6.3). The term ‘come on board’ reflected the size of the area health service; interestingly, the term ‘merger’, which may have indicated a more equal partnership, was never used by participants in this study. Participants frequently described these services as hesitant to hand over management and funding of ‘their’ services due to a lack of trust in the area health service. Many negotiated arrangements of coexistence which were beneficial to both services but did not require the same levels of trust to be invested. This study contributes to the literature related to multi-purpose services by acknowledging that integration is not the only successful outcome of a multi-purpose service development. It is possible to negotiate an improved health service which involves coexisting entities rather than a single integrated entity.
Many participants suggested that rural health services were already following the principles of multi-purpose services prior to their being developed as such. Duffy (1997) indicates that staff in Victorian multi-purpose services had similar perceptions. Some participants in the present study considered that their organisation had been functioning well and meeting community needs prior to the multi-purpose service development and did not see the benefit of the proposed change. These participants frequently adopted the rhetoric of the multi-purpose service model, despite maintaining the identity of the pre-existing services. Perceptions of change varied among participants. This variation resulted in participants from the same multi-purpose service often having very different views on how much change had occurred.

Generally participants acknowledged that the multi-purpose service had led to an improvement in health and aged care services and had enhanced their responsiveness to community needs (see Recognising the Need for Services, Section 6.1.1). Previous literature described the objectives of a multi-purpose health service as being improving flexibility of services, providing health and aged care services more cost effectively, improving coordination of health and aged care services and enhancing the responsiveness of health and aged care services to identified community needs (Sach & Associates, 2000; Hoodless & Evans, 2001). However, these objectives reflect government rhetoric of success rather than the reality experienced by community or staff members.

Andrews et al. (1995) in their national evaluation of pilot multi-purpose services found that major advances had been made towards integration, including the reduction of
duplication, improvement in coordination and linkage of records. These advances were reinforced by the present study as participants invariably described improvements in service provision regardless of whether it was integrated or merely coexisting. However, when examined against the rhetoric of government objectives, full integration, according to participants, had not been achieved across all locations.

Frequently evaluations take place when change has been implemented with the aim of determining whether change has been a success or failure (Vaara, 2002; Sturdy & Grey, 2003). A superficially conducted evaluation may fail to recognise other perspectives which are often inherent in complex social experiences, such as the development of a multi-purpose service. It is important to recognise that different participants are likely to reveal diverse experiences and perspectives (Vaara, 2002, p. 214). In the collaborating phase, participants revealed that collaboration occurred on a continuum where integration was at one end and coexistence at the other. Some participants believed that coexistence was as successful as integration for some health services.

8.5.1 Multi-skilling

Collaborating required staff, particularly nurses, to be multi-skilled because their roles became broader as more services were provided in the multi-purpose service. Staff members who were participants frequently described feelings of isolation and a lack of support to develop and sustain such broad roles. The literature also describes health professionals employed in small rural health services as having a ‘specialist generalist’ role: they are required to be multi-skilled and competent in a wide range of skills (Hegney & McCarthy, 2000; Ricketts, 2000; Hegney, McCarthy, Rogers-Clark, &
Gorman, 2002; Bourke et al., 2004; Murray & Wronski, 2006). This can provide needed flexibility in the provision of health care services in small rural communities which are unable to sustain the employment of several specialists. Other authors (Curran, Fleet, & Kirby, 2006; Allen et al., 2008; Australian Government Department of Health and Ageing, 2008; Francis, Boyd, Sewell, & Nurse, 2008; Kornelsen & Grzybowski, 2008) agree that many rural health professionals feel social and professional isolation which are compounded by the perception of limited access to ongoing education and peer support.

Many participants claimed that ‘staff made the multi-purpose service’ (see Section 6.3.1). In this way the degree of success achieved in developing a multi-purpose service was related to staff acceptance of change. Several authors (Leiter & Harvie, 1998; Gagné, Koestner, & Zuckerman, 2000; Bovey & Hede, 2001; Vakola, Tsaousis, & Nikolaou, 2004) agree that organisational change management is more likely to be successful if employees welcome the change.

Some authors (Giberson, 2001; Vakola et al., 2004) argue that as managers frequently select the staff they employ, this is one way in which managers can influence the organisational culture and the organisation’s ability to change. However, in this study the reality of recruitment in rural health as described earlier in the introduction (Humphreys, Jones et al., 2002; Struber, 2004; Healy et al., 2006; Garling, 2008; Independent Pricing and Regulatory Tribunal, 2008) was so limited that managers did not have much choice in selecting employees. Participants indicated that the health
service was lucky to have sufficient staff and in some circumstances had created the expectation that anyone who met the minimum criteria would be employed.

8.5.2 Developing a New Organisational Identity

An organisation’s identity was described as being important to its development, particularly in cases where mergers occurred (Balmer & Dinnie, 1999; Gustafsson & Hukkanen, 2002; Gardiner, 2003). Hardy, Lawrence, and Grant (2005) indicated that a single organisational identity provided a common issue for employees to address, unlike collaborative partnerships which rarely allowed employees to form close membership ties and a collective vision for the future. This study indicated that participants believed the concept of a multi-purpose service was a good one although it took time to educate people about what the model entailed.

Several participants in the present study expressed confusion about what the new model of health service delivery entailed. Replacing the words ‘hospital’ and ‘health’ with ‘multi-purpose’ left participants confused and suspicious about the future of health services within their community. Additional confusion was described by participants in the present study when some local government councils used a similar term (multi-purpose centre) for their facilities prior to the development of multi-purpose health services. Reid and Solomon (1992) report a similar situation where the name ‘multi-purpose service’ was described as being detrimental to the acceptance of the model by rural communities. These communities were described as fearing they would lose their ‘hospitals’. Reid and Solomon (1992) went on to suggest that the benefits of retaining
the name ‘hospital’ would outweigh those associated with reflecting a new expanded model of health service delivery. The present study adds weight to that suggestion.

The New South Wales Government indicated that there was no obligation to use the name ‘multi-purpose service’, and suggested communities in conjunction with the area health service should determine which name was appropriate for their facility. In fact the Sinclair Report (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000, p. 45) acknowledged that of the eleven multi-purpose services which were functioning in New South Wales at the time of the report, the majority were still referred to locally as ‘hospitals’, despite the aged care sector arguing that the term ‘hospital’ was inappropriate for a place where people resided permanently due to its connotations of illness.

Members of the health industry, who were participants in this study, however, described a need for recognition amongst their peers that the work they were doing had altered, claiming that the new service was ‘more than a hospital’. These staff members and managers, however, did agree that the name ‘multi-purpose service’ was similarly insufficient due to its lack of mention of ‘health’. It did appear that the majority of participants came to terms with the name decided on for their community, but having a variety of names being used by different people did not lend itself to the development of an integrated new identity. Maintaining the term ‘hospital’ led to the perception that acute hospital services were more highly valued and other services were merely adjuncts.
8.5.3 Maintaining a Hospital Identity

The third property of the phase *collaborating* was the rhetoric which was developed by participants to maintain the hospital identity. Not all participants embraced the new multi-purpose service identity. For many participants this was apparent in their language which continued to portray the previous hospital identity.

Keating and Calder (1997) describe the history which developed between a community and its hospital where significant events of the community’s lives, such as births or deaths, occurred, leading to fierce community loyalty and resistance to change. They describe a case study in Victoria where “the community had difficulty understanding the concept of the MPS and was anxious about the future of its hospital” (Keating & Calder, 1997, p. 386). Later Evans et al. (2006) described the same Victorian case study where the health service, although agreeing in principle to become a multi-purpose service, resisted any change in service provision for as long as it could.

Greenhill (2006) also described the development of a public rhetoric which described radical change but in reality that change was never adopted. Instead a balance was reached between change and continuity which allowed the organisation to adapt to a changed environment while reducing uncertainty among organisational members. Maintaining continuity ensured that the organisation remained productive during the implementation of change (Huy, 2002; Ullrich et al., 2005) and allowed valuable cultural traits to be fostered and built upon, balancing continuity and renewal (Davies et al., 2000). Participants in this study also expressed their belief that positive features of
the pre-existing services should not be discarded, despite using the rhetoric which they perceived to be required in some circumstances.

8.5.4 Making Physical Change

The phase *collaborating* also contained the property of making physical change. Physical change was infrequently discussed in the literature related to organisational change. Greenhill (2006) in her research described the Capital Works branch of the Health Department which was responsible for the majority of physical change as ignoring workforce and cultural change, preferring instead to focus on building construction and contractual negotiations. Similarly Evans et al. (2006, p. 96) in their Victorian case study of a multi-purpose service development describe a letter from a regional director which stated that they should implement the multi-purpose service model well before their building was complete as it was “irrelevant to the main interests of MPS”.

However, changing the physical environment has been reported to be important in some European research studies where it has been described as assisting people to come to terms with organisational change (Homburg & Pflessser, 2000; van Marrewijk, 2009). Physical change was also significant to participants in the present study. Participants evaluated the results of physical change carefully, but differentiated between changes which were physical and those in the model of health service delivery.

In multi-purpose services, community focus was frequently related to physical buildings, leading to local frustration when capital works were delayed (Andrews et al.,
1995; Keating & Calder, 1997). In their description of the development of a Victorian multi-purpose service, Keating and Calder (1997) describe physical change as attracting much of the focus of change while the service profile remained largely as it was. They felt that this conveyed a message of continuity with the past, rather than indicating that change was to take place.

Greenhill (2006) describes clinicians complaining about various physical design faults which she interprets as being the result of systemic inertia – the building was designed for changed practices, but as practices did not change (inertia) the design was viewed as a ‘fault’ by participants. In the present study, however, design faults stemmed from trust – architects were trusted to design an appropriate building, but as they were not clinicians they were unaware of what features would be valued (see Expert Knowledge, Section 5.2.1).

8.6 Summary

The central concern of all participants in this study was the *Anticipation of Risk*. *Anticipation of Risk* was based on a judgment of the motives of other people who were involved in the development of the multi-purpose service and led to participants trusting people they perceived to be motivated by altruism. *Trust* and *suspicion* were conceptualised as dimensions of the core category and best results were obtained when there was a balance of both. The core category expanded on previous research by indicating that *Anticipation of Risk* was more personal and undertaken by more participants involved in change processes than was currently documented.
Three phases were identified in the basic social process of ‘Developing a Collaborative Rural Health Service Identity’. These were driving change, engaging with stakeholders and collaborating. The initial phase driving change confirmed the benefits described in the organisational change literature of a need for both local and external efforts to ensure a successful change (Woolcock, 1998; Davies et al., 2000; Fraser et al., 2006; Brown, 2008). In the second phase, engaging with stakeholders, there were four properties, being part of a rural community, working with the health service hierarchy, peer support and time taken. The final phase of the process was collaborating and consisted of the properties multi-skilling, developing a new organisational identity, maintaining a hospital identity and making physical change. These findings add to the limited research which has been undertaken related to multi-purpose services and assists in developing an understanding of the experiences of the stakeholders involved.

A significant contribution which this study has made to the field of health service management is in pulling together as one cohesive theory the issues relevant to participants involved in developing a multi-purpose service and describing their relationship to each other. This cohesive theory was conceptualised as a basic social process of ‘Developing a Collaborative Rural Health Service Identity’. The following chapter will detail recommendations which are indicated by this research and the limitations of the study.
CHAPTER 9. CONCLUSION

This study was undertaken to understand the social experience of participants involved in the development of multi-purpose services and to develop a deeper understanding of that experience. By using grounded theory methodology and interviewing thirty participants, a theory emerged to explain how multi-purpose services were developed in rural New South Wales.

The first chapter of this thesis provided a background of the Australian rural health context and the financial issues which led to the creation of a new integrated model of health service delivery. The multi-purpose service and multi-purpose centre models of health service delivery were both described to distinguish between these two similar models. Multi-purpose services were described as integrated health services combining acute care, aged care and primary health care.

The second chapter reviewed the literature relating to organisational culture and mergers, describing their benefits and issues. The major issue in determining the success of mergers was related to cultural integration, making it important to understand the experiences of people involved in the merger situation. Chapter Two concluded with a review of multi-purpose services and their objectives. The lack of literature relating to multi-purpose services and in particular their development supported the need for further research in this area.

The third chapter analysed the constructivist paradigm, grounded theory methodology and symbolic interactionism which were used in this study. The suitability of each for understanding the experiences of people involved in the development of multi-purpose
services was determined. This chapter concluded with a description of the major features of grounded theory to explicate methodological issues.

The fourth chapter provided a detailed description of the methods used in this thesis demonstrating, with examples from the data, how the grounded theory method has been applied in this study. In total thirty participants were interviewed and they often indicated their appreciation of having an opportunity to reflect on their experiences. Data generation and analysis took place simultaneously and involved theoretical sampling, in-depth interviewing, open coding, constant comparison of data and theoretical coding in order to co-construct a substantive grounded theory together with the participants.

Chapters Five and Six presented the core category *Anticipation of Risk* and the emergent three-phased basic social process which participants experienced; both chapters provide supporting evidence from the data. Chapter Seven drew together the findings from Chapters Five and Six into a substantive grounded theory, ‘Developing a Collaborative Rural Health Service Identity’. The theory demonstrated how the core category and three phases interacted with each other.

Chapter Eight related the substantive grounded theory to the relevant literature, comparing and contrasting it to the findings from this study. In comparing the emergent substantive grounded theory to current literature, it was obvious that no research had previously been undertaken in this area. The focus of a grounded theory methodology on the main concerns of participants ensured that this research was relevant to people involved in the development of multi-purpose services.
This final chapter will describe the major implications of the findings and make recommendations for the future development of multi-purpose services (particularly in relation to managers and community engagement) and for further research. This chapter will also present the strengths and limitations of the present study.

9.1 Major Findings and Recommendations from this Study

The present study was designed to understand the experiences of participants who had been involved in the development of multi-purpose services in rural New South Wales. Each multi-purpose service was to meet the needs of a unique community making each one different and limiting the ability of people to develop expertise in this area. The major findings from this study which follow provide evidence for the formation of twenty-one recommendations to guide and inform the future practice of people involved in health mergers or the future development of multi-purpose services.

**Recommendation 1.**

*When developing a health service which specifically addresses the unique needs of a community, significant value should be placed upon the expertise of local stakeholders due to their local knowledge.*

The constant comparison of data collected from participants enabled the identification of a core category, *Anticipation of Risk*, which frequently occurred in the data, indicating it was a central concern to all participants. Participants anticipated risk based on their judgment of the motives of other people who were involved in the development of the multi-purpose service. Despite risk management literature suggesting that managers formally assess risk (Adler & Kranowitz, 2005; Kytle & Ruggie, 2005;
Cotton, 2009; Mendonça & Sapio, 2009; Sympson, 2009), the anticipation of risk was a more personal assessment which was undertaken by all participants in the present study. When participants judged people to be motivated by altruism, they were more likely to trust those people. Building trust among participants reduced the time taken to complete the process through negating the need to convince others of a plan of action. Participants also revealed that suspicion, while delaying progress, provided more participants the time they required to be actively involved in the process and to have their needs addressed. When participants reflected on their involvement in multi-purpose service development they frequently felt that their suspicion had been justified, particularly when other people were judged as being motivated by their own self-interests. This suspicion slowed the process of developing multi-purpose services protecting against hasty decision making and encouraging careful negotiation of outcomes by all participants. Balancing trust with suspicion allowed the development of a model of health service delivery which met the needs of a community of stakeholders rather than just a trusted few individuals. Despite trust frequently being perceived by participants as a positive attribute, the data collected in this study indicated that suspicion should be equally valued to ensure that diverse opinions are heard.

**Recommendation 2.**

*During times of organisational change, a healthy balance of trust and suspicion should be encouraged to allow change to be negotiated while ensuring that issues are heard and addressed in a timely manner.*

A basic social process ‘Developing a Collaborative Rural Health Service Identity’ was identified which described the movement of participants through three phases driving
change, engaging with stakeholders and collaborating. The first phase of the basic social process of driving change demonstrated the benefits of combining local and external drivers of change, which is similar to the top-down and bottom-up change efforts discussed in the organisational change literature (Woolcock, 1998; Davies et al., 2000; Fraser et al., 2006; Brown, 2008). The phase driving change was conceptualised as having three properties, recognising the need for services, economic issues and ownership. Aged care services were highly valued by participants and the multi-purpose service was considered to have been effective in addressing this need in particular. Despite improvements in service provision being recognised by most participants in this study, community members frequently maintained their hope for a return of obstetric and surgical services.

Recommendation 3.

There needs to be a clear and transparent discussion about which services can be provided in the multi-purpose service. In order to overcome suspicion, this should include discussion about services which have been provided historically and are no longer available, even if this discussion has occurred previously.

Frequently local participants maintained their suspicion that economic issues had driven the development of the multi-purpose service even years after the development had been completed. Local participants were well aware of the broad financial benefits which the health service provided for their community and viewed such investment as altruistic, improving their trust of the health service and its employees.
Recommendation 4.

Improving community knowledge of the funds being invested in their community through the development of a multi-purpose service (e.g. overall cost of the project, number of local workers employed) will improve community trust in the health service and the new model of health service delivery.

Recommendation 5.

Commonwealth and State Government departments need to prevent adverse impacts on local businesses and people by purchasing locally where possible.

Government rhetoric which called for a sense of community ownership of the multi-purpose service (National Rural Health Alliance, 1996; NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000) was threatened by peppercorn arrangements which were perceived by local participants to indicate that facilities they once controlled were no longer under their control – reducing their sense of ownership of the new facility.

The second phase of the basic social process was engaging with stakeholders. This phase was conceptualised as having four properties, being part of a rural community, working with the health service hierarchy, peer support and time taken. The community members who participated in this study expressed great interest in their health service. They were active members of their communities and engaging them in the development
of the multi-purpose service had obvious benefits, including their ability to lobby the
government – local and even the state-wide media. The consultation which participants
described in this study was frequently perceived as being manipulated or ignored by the
health service, creating suspicion. Rather than attempting to manage consultation
processes a common ground needs to be reached in order to build trust between
participant groups (Senior & Chenhall, 2007; Wiseman, Williamson & Fritze, 2010).

**Recommendation 6.**

Explicit guidelines describing government expectations of community
engagement in health service delivery should be introduced and should
focus on the need to reach a common ground, rather than a need to manage
the consultation and its outcomes.

Community members did need to be informed in order to effectively participate in
decision making, however, combining community education with community
consultation was perceived to be manipulative by participants in this study.

**Recommendation 7.**

Community education should be clearly separated from community
consultation.

This phase confirmed the value local participants placed on being part of a rural
community. Despite some participants who were community members demonstrating
suspicion of having staff members on committees to develop the multi-purpose service,
there was suspicion amongst all groups of participants when they were refused such
positions.
Recommendation 8.

Community committees which are formed to develop multi-purpose services should not exclude staff members or managers as members if these people live within the community.

A major finding of this research was the personal nature of the core category of *Anticipation of Risk*. All participants engaged in *Anticipation of Risk*, based on a personal judgment of the motives of other participants. The personal nature of this judgment placed local health service managers in a prominent position as leaders and this was largely due to their immediate and visible accessibility by other participants.

Recommendation 9.

Local managers should be acknowledged as an effective connection between government bodies, the area health service and the community. They should be encouraged to build upon the *trust* they inspire within the community by advocating from the perspective of the local community.

Local managers were frequently described by participants as being limited by poor sources of information, a lack of resources (including suitable staff), decision making power, time and education. Literature related to middle managers involved in organisational change indicates that this is not an unusual situation (Ullrich et al., 2005; Greenhill, 2006; Kavanagh & Ashkanasy, 2006; Marshall, 2009; McGurk, 2009).
Recommendation 10.

Local health service managers need to be provided with accurate information and greater decision making power to enable them to manage organisational change effectively.

Recommendation 11.

Local health service managers should be provided with education about community engagement and additional resources, including suitable staff and time to deal with the additional workload involved in the development of a multi-purpose service.

The ability of existing staff to multi-skill was significant to the success of the new multi-purpose service. In order to ensure that staff members are able to multi-skill, greater opportunities need to be provided for education.

Recommendation 12.

Postgraduate and inservice education should be developed specifically to meet the needs of generalist staff employed in multi-purpose services. Staff should be encouraged to participate in further education, with particular consideration given to providing financial support to travel and backfill positions.

Participants described the benefits they derived from peers who had been through the process of developing a multi-purpose service previously. Despite several
recommendations in the literature to create formal support mechanisms related to multi-purpose services (Andrews et al., 1995; Hall & Medley, 2001; Eccles, 2002; Department of Human Services (Vic) & Department of Health and Ageing, 2003), few of these were identified by participants in the present study.

**Recommendation 13.**

Regular meetings within area health services should be held specifically for managers and community committees involved in multi-purpose services.

Participants in this study indicated that considerable time was required to develop a multi-purpose service effectively and were accepting of lengthy time frames. However, if the development was not seen to be completed within suggested time frames suspicion was increased.

**Recommendation 14.**

Realistic time frames should be announced for the completion of a multi-purpose service, rather than tight time frames which may need to be extended in unforeseen circumstances.

The final phase of the process was *collaborating* and consisted of the properties multi-skilling, developing a new organisational identity, maintaining a hospital identity and making physical change. Despite government objectives of a single integrated multi-purpose service, participants in this study indicated that less integrated multi-purpose services could be a more effective outcome for some communities, stressing another government objective – that of meeting unique community needs.
Community members often had a poor understanding of the model of health service delivery being used. A change from a hospital model to a multi-purpose service model was described by participants as sounding very generic (not mentioning hospital or health in the name) and enhanced the suspicion that their health services would be withdrawn.

**Recommendation 15.**

The multi-purpose service model needs to be clearly described to communities. Consideration should be given to the significance of the name, ‘multi-purpose service’ to rural communities.

Participant responses in this study generally confirmed the results of multi-purpose service evaluations which indicated that health care services were improved through the development of a multi-purpose service. Improvements in aged care in particular were considered to be important to these participants.

**Recommendation 16.**

Multi-purpose services should be developed in small rural communities which demonstrate an unmet need for residential aged care facilities.

These findings lead to a greater understanding of the experience of people involved in the development of multi-purpose services and indicate several recommendations for managers and further education and research.
9.1.1 Recommendations for Education

Further study needs to occur to determine what education is most necessary for local health service managers to successfully develop multi-purpose services and to engage communities effectively (see Recommendation11). The need for education for community and staff members also arose from this study.

**Recommendation 17.**

*Education should be provided specifically to community members about: the new model of health service delivery to be implemented; why it is being implemented; and the impact it will have on their community.*

**Recommendation 18.**

*Education should also be provided to staff members about: the new model of health service delivery; why it is being implemented; how it will impact on their work; and how it will be implemented.*

9.1.2 Recommendations for Further Research

This study has investigated and documented the experiences of participants in the development of a multi-purpose service in rural New South Wales. A three-phased basic social process was described with a core category *Anticipation of Risk.*
Recommendation 19.

The basic social process which emerged from this study could be operationalised through a case study or action research in a similar context.

A review of the quality of care provided by multi-purpose services could include structure, process and outcome (Donabedian, 1997). Currently multi-purpose services have a variety of features to meet the needs identified for each individual community. A review of structure would include material resources, human resources and organisational structure.

Recommendation 20.

A review of the structure of multi-purpose services could indicate which features and services should form part of a standard format and which are unlikely to be a successful component of a multi-purpose service.

Future research to develop measures of process and access to the service would provide information on how they could be improved. Ongoing evaluation of interventions should take place, for example, to determine measures of effectiveness and the patient’s perspective and degree of satisfaction. This type of research would inform health services in order to improve patient care and meet community needs.
Recommendation 21.

Evaluations of the effectiveness of multi-purpose services in meeting health needs should be undertaken, with particular emphasis on outcomes which could be benchmarked between similar services.

9.2 Strengths and Limitations of the Study

The strengths and limitations of this study need to be taken into account to appraise the substantive theory which has been produced. The aim of the study was to understand the social experience of participants involved in the development of multi-purpose services in rural New South Wales and to understand how participants dealt with those concerns. As described in Chapter Four, this study was evaluated using the criteria (credibility, originality, resonance and usefulness) described by Charmaz (2006).

As demonstrated in Chapter Three, grounded theory was a suitable methodology to understand the social experience of participants involved in developing multi-purpose services and to understand how they dealt with those concerns. Prolonged data generation and the grounded theory method of checking that categories within the data were replicated by multiple participants (constant comparative analysis) also added to the credibility of the study. The constructivist grounded theory described by Charmaz (2006) was followed consistently as is evidenced by the description of its application in Chapter Four. The findings presented in Chapter Five describe the core category which was the main concern of participants, and the following Chapters Six and Seven describe how participants dealt with that concern in the development of multi-purpose services. The grounded theory method of allowing theory to emerge from data ensures
its credibility and the provision of direct quotes demonstrates this process (Chapters Five and Six).

The grounded theory method of allowing theory to emerge from the data about participant experiences also ensured the originality of the study, particularly as the present study targeted a rural context which had not been researched previously (Chapter Two). The discussion chapter (Chapter Eight) also compared and contrasted the findings of the study to current literature to highlight original findings. As this substantive grounded theory is grounded in the experiences of participants involved in the development of multi-purpose services rather than experts, it is unique in this context and may have resonance for participants involved in other forms of organisational change also.

Resonance was achieved by presenting the emerging theory to subsequent participants to ensure that they recognised their own experience in the findings and encouraging them to add any facets of their experience which may have been overlooked. Co-constructing the emerging theory with participants in this way and returning to the original participant at the end ensured that they also resonated with the emergent theory. Conference presentations invited audience feedback and indicated resonance with preliminary findings (Anderson & Grootjans, 2007a, 2007b; Anderson et al., 2009).

The substantive grounded theory which was constructed during this study is considered useful in that it provides descriptions and interpretations of the experiences being studied. The process of co-constructing the theory together with the participants allowed them to make modifications which they felt would be useful to their practice. The theory can be applied to small rural health services undergoing a change in their model.
of health service delivery to describe what is or has occurred in these locations and offers an interpretation of the process. Several recommendations have emerged from the findings, suggesting how the theory can be applied to practice.

A major strength of this study was that it was undertaken in an area which had not been studied extensively before. For people living in small rural towns in Australia, which have been targeted for development of multi-purpose services, this research has significant implications. Managers, particularly those who are tasked with developing successful multi-purpose services, can benefit from strategies based on the information developed through this study. Other managers who are involved in community engagement may also resonate with these findings.

Although this study has several strengths, weaknesses also exist. The study was designed to be exploratory and generate a substantive grounded theory which should aim to account for a pattern of behaviour which is problematic for the participants. Being driven by the main concern of participants a grounded theory study focuses on the concerns which they feel are important (Glaser, 1978). Grounded theory initially produces a substantive theory that can only be generalised (or transferred) to the context that it originates from. Although it is limited, it ensures it is original, has specificity and applies to the setting and situation that were studied (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1990). The participants in this study were limited to one area health service. One ex-staff member and two managers had experience in different area health services and, although there were no obvious differences related by these three participants, this was insufficient to generalise to other area health services. This limitation of the current study was acknowledged and expected.
The study was exploratory as little study (see Literature Review, Chapter Two) has taken place in relation to the development of multi-purpose services, partially due to the relatively recent acceptance of the model. Interviews were undertaken between 2006 and 2007 at which time participants indicated that the multi-purpose service model was still not familiar to everyone who was involved in the development. Contextually this was an appropriate time for this study as further multi-purpose services are planned and only case studies have been undertaken at this stage in relation to their development.

In-depth interviews as used in this study were designed to understand the perspectives of participants rather than sample large numbers. This resulted in a contextual study limited to one area health service. Participants were interviewed retrospectively about their experiences with the development of multi-purpose services and their ability to recall accurately after the experience may have affected some of the data generated. The intent of this research was to inductively describe the development of multi-purpose services by allowing participants to explain their experiences of the change to the rural health service.

9.3 Final Comment

This study was aimed at exploring the experiences of participants involved in the development of multi-purpose services in rural New South Wales. The grounded theory method was used to enable the identification of a three-phased basic social process. A substantive theory ‘Developing a Collaborative Rural Health Service Identity’ emerged. In the final phase multi-purpose services were perceived by participants to have improved outcomes, particularly in relation to improved collaboration between pre-existing services and improved provision of local aged care services. Participants
reported that collaboration between pre-existing services did improve although not necessarily resulting in the integrated health service espoused by government rhetoric. Participants in this study also acknowledged the economic benefits which New South Wales Health obtained through adopting the multi-purpose service model which allowed it to attract Commonwealth funding for aged care residents.

In its constructivist approach this study has provided an opportunity for participants to co-construct a theory based on their experiences in the development of multi-purpose services. It adds to the limited literature which exists about multi-purpose services and extends this literature by examining the development of such services. These findings enhance the ability to understand the organisational change which took place and will enable managers to improve their management of such a process.
REFERENCES


Allan, J., Ball, P., Alston, M., & Alston, J. (2008). ‘You have to face your mistakes in the street’: the contextual keys that shape health service access and health workers’ experiences in rural areas. Rural and Remote Health, 8, 835.


References


Dietsch, E., Davies, C., Shackleton, P., Alston, M., & McLeod, M. (2008). ‘Luckily We Had a Torch’: Contemporary Birthing Experiences of Women Living in Rural and Remote NSW. School of Nursing and Midwifery, Faculty of Science, Charles Sturt University.


References


National Rural Health Alliance, & Aged and Community Services Australia. (2004). *Older People and Aged Care in Rural, Regional and Remote Australia*. Canberra, ACT: Aged and Community Services Australia & National Rural Health Alliance.


APPENDICES

Appendix 1: Ethics Approvals

6 July 2006

Ms Judith Anderson
School of Nursing & Health Studies
BATHURST CAMPUS

Dear Ms Anderson,

Thank you for the additional information forwarded in response to a request from the Ethics in Human Research Committee.

The Committee has now approved your proposal entitled "A qualitative review of the change process which occurs in small rural health services during mergers". The protocol number issued with respect to the project is 2006/191. Please be sure to quote this number when responding to any request made by the Committee.

You must notify the Committee immediately should your research differ in any way from that proposed.

You are also required to complete a Progress Report form, which can be downloaded from www.csu.edu.au/research/forms/ehre_annrep.doc, and return it on completion of your research or by 6/07/2007 if your research has not been completed by that date.

Please don't hesitate to contact the Executive Officer telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries about this matter.

Yours sincerely,

Julie Hicks
Executive Officer
Ethics in Human Research Committee

Cc: Dr John Grootjans Dr L. Stockhausen
15th September, 2006

Mrs Judith Anderson
PO Box 9054
BATHURST NSW 2795

Dear Mrs Anderson,

Re: GWAHS HREC Reference No. GW/2006/12
A Qualitative Review of the Change Process Which Occurs in Small Rural Health Services During Mergers

Thank you for responding to the HREC's clarification request for the above project. The HREC considered you responses at its meeting held on 6th September, 2006. This HREC is constituted and operates in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Research Involving Humans and the CPMP/ICH Note for Guidance on Good Clinical Practice.

I am pleased to advise that the Committee has granted ethical approval of the above project.

Please provide the HREC with a copy of your amended Consent Form.

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   - any serious or unexpected adverse events; and
   - unforeseen events that might affect continued ethical acceptability of the project.

2. The Principal Investigator will report proposed changes to the research protocol, conduct of the research, or length of HREC approval to the HREC in the specified format, for review.

3. The Principal Investigator will inform the HREC, giving reasons, if the project is discontinued before the expected date of completion.

4. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.
The HREC also has delegated authority to approve the commencement of this research on behalf of Greater Western Area Health Service. This research may therefore commence.

Should you have any queries about your project please contact the HREC Executive Officer on (02) 6339 5601.

Please quote HREC Reference No. GW2008/12 in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely

Suzanne Degiorgio  
The Secretary

For

Dr Anthony Brown  
Executive Officer

Human Research Ethics Committee

Greater Western Area Health Service
Appendix 2: Map of Multi-purpose Services
Appendix 3: Participant Information Sheet

INFORMATION FOR PARTICIPANTS

The research will take the form of individual interviews. In these discussions we will be interested in hearing your experiences of change and the culture of the health service during the development of your multi-purpose service. The interviews will be approximately one hour in duration and be digitally recorded and transcribed. This collection of data will take place over a twelve-month period. The information will be made available to other health services as they go through a similar process in order that they can learn from your experiences. It will be published in the form of journal articles, recommendations, guidelines or presentations.

You have been invited to participate in this study, which involves your health facility. The project is being run as part of a postgraduate degree from Charles Sturt University (CSU). The Principal Investigator is a student, Judith Anderson. Her supervisors are Dr John Grootjans (02 9351 0524) and Dr Margaret McLeod (02 6933 2388).

If you experience any discomfort we would encourage you to contact the Greater Western Area Health Service Employee Assistance Program, who are aware of this project and willing to assist you as required (John Wilby, 1800-357-898).

You should understand that you are free to withdraw participation in the research at any time. Participation or withdrawal from the research will not be reported within the Greater Western Area Health Service and will not affect your relationship with the Greater Western Area Health Service, and you will not be subjected to any penalty or discriminatory treatment. The investigator will tape recording your interview as part of this project. Any information or personal details about you gathered in the course of this research will be confidential and your name or any other information that could identify you will not be used in any report or publication without your written permission.

We hope that you decide to join the study and enjoy participation. If you would like to participate please complete the attached Consent Form and we will contact you to organise an interview which should last approximately one hour.

We look forward to your involvement. If you have any queries about this study please call Judith Anderson, (02) 63325416.

NOTE: Charles Sturt University’s Ethics in Human Research Committee and The Greater Western Area Health Service Human Research Ethics Committee have approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committees through the Executive Officer:

The Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795
Tel: (02) 6338 4628
Fax: (02) 6338 4194

The Executive Officer
The Greater Western Area Health Service Human Research Ethics Committee
PO Box 143
Bathurst NSW 2795
Tel: (02) 6339 5601
Fax: (02) 6339 5555
If you are interested in participating in this study, please don’t hesitate to contact me:

Phone: 0417 293 353

E-Mail: Judith@ix.net.au

Or return this form:

By mail:
Judith Anderson
School of Nursing & Health Science
Charles Sturt University
Bathurst NSW 2795

Or fax:
(02) 6332-2519

and I will contact you.

Name:
Position/Role:
Mailing Address:
Telephone:
Appendix 4: Consent Form

CONSENT FORM

Name of Research Project
A qualitative review of the change process which occurs in small rural health services during mergers.

Name, Address and Phone No. of Principal Investigator and Student
Judith Anderson
School of Nursing & Health Science,
Charles Sturt University,
Bathurst, NSW 2795
(02) 6332 5416

Name, Address and Phone No. of Principal Supervisor
Dr John Grootjans
Faculty of Nursing and Midwifery
University of Sydney
(02) 9351 0524

The purpose of the research has been explained to me and I have read and understood the information sheet given to me. I have also been given the opportunity to ask questions about the research and received satisfactory answers.

I understand that I am free to withdraw my participation in the research at any time. My participation or withdrawal from the research will not be reported within the Greater Western Area Health Service and will not affect my relationship with the Greater Western Area Health Service, and I will not be subjected to any penalty or discriminatory treatment.

I agree to the investigator tape recording my interview as part of this project. I understand that any information or personal details about me gathered in the course of this research will be confidential and that my name or any other information that could identify me will not be used in any report or publication without my written permission.

NOTE: Charles Sturt University’s Ethics in Human Research Committee and The Greater Western Area Health Service Human Research Ethics Committee have approved this project. I understand that if I have any complaints or concerns about this research, I can contact:

The Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795
Tel: (02) 6338 4628
Fax: (02) 6338 4194

The Executive Officer
The Greater Western Area Health Service
Human Research Ethics Committee
PO Box 143
Bathurst NSW 2795
Tel: (02) 6339 5601
Fax: (02) 6339 5555

Signed by: ............................................................ Date of Birth: .........................

Print name: .......................................................... Date: ...............................