Author’s response to reviews

Title: How much is too much? An academic's perspective of participation in healthcare redesign

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Reply comments to reviewers:
The authors would like to thank both reviewers for their comments and valuable contributions to this paper. Please find specific comments to each reviewer below.

Reviewer #1:
Going through this paper I have found out that it faces with several setbacks unless this paper it is intended to be published under commentary section:
Are the authors are addressing this paper to nurses, doctors or both (seems most of their references is from nurses articles (that means the article is emphasizing on the role of nurses).
This paper is intended to address all healthcare practitioners involved in the improvement of health services. The majority of references from nursing articles is because much of the current health service redesign projects are undertaken by nursing staff or are aimed at nursing practice.

It is well known that a lot of clinical researchers they are chairs in their domain and are capable in evaluating health services because they are clinicians and academicians at the same time.
Building on this, I believe the authors should declare that this study is limited to Australia and keep mentioning it as to Australia or the region they are address too and make comparisons between regions and provinces or states within Australia.
Thank you for the suggestion, the authors have more overtly indicated this paper refers to the Australian context. The background section includes that this study is based on Australian practice, however the references utilised also take into account other countries perspectives and studies including the USA, UK and Canada. This paper is not denying that clinical researchers are capable of evaluating health services because they are clinicians. We are aiming to show that there can be conflicts in the academic involvement during health service redesign, as well as benefits.

Also the authors could make comparisons Australia and with other OECD countries and developing
countries. There are countries where clinicians are not experts in health care redesign and they require the assistance from academics to draw a new health care redesign especially countries with limited human resources as it is applied to some African, South Asian, and Middle Eastern countries. The authors need to mention different healthcare redesigns that succeeded in different regions or states and elaborate about the reason of their success or their continuous re-evaluation.

In this paper the authors are giving their perspectives on the use of academia in health service redesign. There are definitely countries where health service redesign expertise comes mostly from academia, however lengthy comparisons of these countries is outside the scope of this paper. As indicated by Reviewer 1 further research into this area would be very beneficial.

The authors need to evaluate the reasons for the success in the healthcare redesigns in different programs around Australia and the where healthcare redesign projects had failed. The authors need to illustrate the quality of life in patients after implementing the healthcare redesigns at least in couple projects around Australia and compared it to other projects done in other countries.

Thank you for the suggestion. Examples of Australian findings from XX projects are now included. While comparisons are a very important issue and part of healthcare redesign – it is outside the scope of this paper which focuses on the process of the tensions within clinical redesign. The aim of redesign is to improve patient experience and patient care in the context of how academics and clinicians can work together to deliver these outcomes. A comparison of the reasons for success or failure is a more clinical view and would involve the inclusion of a literature review to establish parameters. Although the authors agree this is a worthy topic for the future, it is not within the scope of this paper.

The authors should acknowledge that the OECD countries have the well trained health care professionals that have the expertise in building a healthcare redesign and they have multidisciplinary teams including project management consultants. This paper focuses on the Australian context. The opening paragraph acknowledges clinical redesign occurs internationally. The authors are not denying that some healthcare professionals have expertise in redesign and that MDT are available for this work, including project management consultants. We are aiming to show how academics can be of assistance (and vice versa) in the development and execution of redesign work within healthcare in Australia.

At least give a brief background of Australia health care system how it progressed and reached to Universal coverage.

Thank you for the suggestion. The authors have considered the suggestion and have concluded the focus of the paper is redesign within the Australian context. However, provision of the complexity of the Australian healthcare system would not add to the paper, but it was felt would be more likely to confuse the reader. A background of the Australian Health care system may not provide any value for this paper as we are not specifically discussing Australia, rather, health service redesign as it applies globally. Whilst our perspective is from the Australian context, the principles of health service redesign and the involvement of universities can be applied in many different health care systems.

Reviewer #2:
I would like to thank the authors for the interesting manuscript that I enjoyed reading. Because I teach a graduate course on managing quality with teams using as a main content process mapping and redesign, the content of the manuscript resonated with my interests. Nevertheless, for readers who are not familiar with such concepts and the international professionals, it could be better to stick to the purpose of the paper "... provides an academic perspective of both benefits ... and pitfalls...", that is to say, show clearly the benefits and the pitfalls in separate sections.
Thank you for your comments. The authors have attended to paragraphs to improve readability and flow and clearly demonstrate the benefits and potential pitfalls within the clinical redesign process.

A few more comments:

Page 4, under background, paragraph 3, lines 101-102, kindly elaborate what kind of conflicts in workload.
Thank you, completed.

Page 5, under "What is healthcare redesign?", is there a more updated recent definition or is the one you choose to consider?
The authors believe this is the most suitable definition to support the tenet of this paper.

Page 7, under "Developing partnerships", lines 155-156, please be consistent in putting a comma after the citation: Human factors such as shared vision [remove ,] (Lorden et al 2014), readiness (Al Balushi et al 2014) [put comma] leadership, assigned workload (Lorden et al 2014) [put ,] engagement and 'buy-in' (Sahs et al. 2017), ritual or resistance (Waring & Bishop 2010) ...
Thank you, the manuscript has been proof-read and edited to improve clarity, consistency and readability.

Page 11, under "Project deliverables/outcomes (publications)", why selecting publication only to be included in the title? Line 272, (ref) to be added; line 275, Rathmell [delete &] and Sandberg thank you, completed.