

Insider knowledge and outsider objectivity

– the benefits and risks of combined evaluator roles in a study of health care reform

This paper describes the experiences of the authors in conducting a three year evaluation of health system reform processes in the southern region of Adelaide and explores how the evaluation team utilised ‘insider’ and ‘outsider’ roles to establish and maintain trust and cooperation with stakeholders and informants in a turbulent policy environment. It uses the results of focus groups and interviews to analyse how the team was able to encourage the sharing of sensitive information and to examine the roles, responsibilities and risks to evaluators in carrying out a controversial evaluation. The importance and some means of finding a balance between insider knowledge and outsider objectivity in evaluation are discussed.

Introduction

This paper draws on the experiences of the authors in conducting a three-year evaluation of health system reform processes in the southern metropolitan region of Adelaide and explores how the evaluation team combined outside and inside evaluators and managed to establish and maintain trusting relationships with stakeholders and informants in a turbulent and highly charged environment. The literature on evaluation gives only brief attention to the advantages and disadvantages of being an internal or external evaluator. This paper will draw on the experiences of conducting an evaluation of health system reform in order to analyse more fully how the composition of the team encouraged the sharing of sensitive information in a situation dominated by tension between health care providers and bureaucrats. It will also examine the role, responsibilities and risks to evaluators in such a situation, and the importance of finding a balance between insider knowledge and outsider objectivity.

Literature on insider and outsider evaluators

Insider evaluators, defined as people who are involved with the implementation or outcomes of the program (Owen 1993), are seen to have strengths in the area of

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The Health Care Reform in Southern Adelaide Evaluation Project, which aimed to promote collaboration between the services and the running of regional projects, changed as a result of a shift in the political context. This shift occurred following the formation of a combined Department of Human Services (DHS), incorporating the South Australian Health Commission, and the Departments of Housing and Community Services in late 1997. This was followed by a new policy direction seeking to move all major decision-making power to the central department's Executive management group and to an emphasis on integration of the three areas, both in the field and centrally. As a result, the regional health service proposal was not supported by the DHS Executive and did not proceed. This in turn meant that the original evaluation proposal had to be reframed.

Following consultation with the participating agencies, the evaluation project was recast into one that examined the processes and outcomes of health service reform in southern Adelaide during the three years, the impact these changes had on levels of interagency collaboration and the perceptions of both the 'field', that is, the health service providers and their managers, and the 'centre' or central bureaucracy stakeholders.

The focus of this paper is on the final year of the project, as it was during 2000–01 that results of the evaluation were beginning to be presented at conferences, in journal articles and in discussions with stakeholders through focus groups and seminars. While trust had been a significant issue

since the start of the project, it was in this last year that the issues surrounding the relationship between the evaluators as outsiders/insiders and the various stakeholders became most significant largely because the research findings were being made public.

Composition of the evaluation team

The evaluation was initiated at the suggestion of one of the CEOs of the four organisations proposing the formation of the regional health service. The teaching hospital CEO, the Professor of Public Health and the Professorial Fellow in the Health Service Management Development Unit were the initial Chief Investigators for the evaluation. The Professor of Public Health also has another role as the Director of a community health research unit, funded by the Department of Human Services, and with a long and respected track record in the evaluation of community health services. The Professorial Fellow was a past CEO of the major teaching hospital, now working as a teaching consultant with the Health Service Management Development Unit at the university. This unit was also funded by DHS.

The bulk of the funding for the evaluation was provided by a grant from the ARC SPIRT (Australian Research Council Strategic Partnerships with Industry, Research and Training) fund. The 'industry partners' were the four health services and the SA Health Commission, later the Department of Human Services. All had representatives on the

TABLE 2: OUTSIDER AND INSIDER ROLES OF THE EVALUATION TEAM MEMBERS FOR THE HEALTH CARE REFORM IN SOUTHERN ADELAIDE EVALUATION PROJECT.

| <i>Evaluation team member</i> | <i>Outsider position/role</i> | <i>Insider position/links</i> |
|-------------------------------|---|--|
| Chief Investigator A | Professor of Public Health, university | Member of School of Medicine and known to local clinicians Director of DHS-funded research unit |
| Chief Investigator B | Professorial Fellow and university lecturer | CEO of teaching hospital |
| Chief Investigator C | | Past CEO of teaching hospital. Consultant at university unit funded by DHS Historical knowledge of health services in the area |
| Partner Investigator | | CEO of smaller hospital Knowledge of 'central' directives and impact on the 'field' |
| Senior Research Associate | Appointed to the evaluation project from July 1998 – May 2001 One day per week from May – December, 2001 | Seconded from DHS Returned to new position within DHS, four days per week in May 2001 |
| Research Officer | Appointed to project, three days per week from Oct 2000 – May 2001 | Past worker in one of partner agencies |

evaluation Steering Committee. Finally, the majority of the evaluation activities were carried out by a Senior Research Associate, seconded in 1998 from her position as a Principal Policy Officer in the South Australian Health Commission. In late 2000, a Research Officer was employed to conduct a process evaluation of a management forum for the project (detailed below). She had past experience as a health care worker in one of the four agencies and recent experience in evaluating health system change.

The outsider and insider roles and positions of the evaluation team are summarised in the table on p. 62. The Professor of Public Health (Chief Investigator A) was part of the university School of Medicine and was known to most of the key clinicians in the hospital. She also had a high profile and respected research reputation in the community based services. Her role could be defined as chiefly an outsider but with insider links including her directorship of the state funded community health research unit. The CEOs of the teaching hospital and other three agencies involved provided high level support both to the process of seeking to form a regional health service and to the evaluation itself. Their 'insider' input provided the evaluators with information about what was happening on the ground in health services in the region. The past CEO of the teaching hospital (Chief Investigator C) was able to provide a historical perspective, both on local changes in the health care system (he had worked as a manager in the southern area since the teaching hospital was opened, twenty five years ago) and in his knowledge of the events and trends that have shaped health services, both nationally and internationally. The Senior Research Associate continued to receive occasional input from her colleagues in the Department of Human Services about the current political and policy issues and the organisational climate.

However, as is almost inevitable in any longer term project, the evaluation team was affected by turnover. The CEO of the teaching hospital (Chief Investigator B) who had developed the evaluation proposal in conjunction with the Professor of Public Health left to take up another post in late 1998, followed by another key participating hospital CEO in early 2000. By the time the project was in its final year, only one CEO (Partner Investigator, from the smaller teaching hospital) was actively involved in the Evaluation Project Team. This CEO provided valuable advice and input on current policy directions he was receiving from the Department of Human Services and the reaction of staff to these. Despite these changes, the consistency of the Professor of Public Health as Chief Investigator and the Senior Research Associate were mitigating factors. One final change that did affect the operation of the team was that the secondment of the Senior Research Associate ended in May 2001. She returned to a position in the Department of Human Services but continued to work on the evaluation one day per week. The implications of this

change in status will be explored more fully below.

Methods

Full details of the methods used during the course of the evaluation have been documented elsewhere (see van Eyk, Blaum & Blandford 2001). In summary, the project used an action-research framework that enabled it to adapt to the changing policy context and also to feed back emerging findings to key stakeholders, receive their input and use this 'insider perspective' to inform subsequent stages of the evaluation. Input from agency managers and staff on the impact of health system reform and organisational changes on their work and their agencies was sought through:

- surveys (mail and telephone)
- case studies
- interviews
- focus groups.

The evaluation also used document analysis, observation and media analysis to track changes in the health system and the health care agencies. This article focuses on the data gathered in focus groups and interviews, as it was in these that the issues of information sharing and trust in the outsider evaluators with insider connections were most evident.

Focus groups highlighting the tensions between the centre and the field

A total of four focus groups with representatives from the four health care agencies and a separate focus group to present the results to the Senior Executive of DHS were held over a period of five months. Originally a seminar involving both service providers and DHS Senior Executives had been proposed. However, various issues including the agency CEO's concerns that such a meeting would lead to negative repercussions for their already difficult relationships with the department rather than a constructive discussion of the issues and difficulties organising a suitable time, meant that the seminar did not proceed. The focus groups were chosen as a means of gathering data and sharing feedback about the results of the project to date in a way that avoided exacerbating existing problems and with the hope that they might help participants to

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understand the challenging context in which they were working.

Participants (n=27) in the first three groups were key clinical and administrative staff from the four agencies. The fourth group (n=3) consisted of the CEOs of the four agencies and the fifth group (n=7) with members of the DHS Senior Executive. The first four groups were considered to represent the 'field' and the fifth group, the 'centre'. Field respondents were asked to comment on:

- how they viewed the current moves toward integration and away from regionalisation
- how the new directions had influenced inter-agency collaboration
- the implications of continuing change for service delivery.

All focus groups were conducted by Chief Investigator A with the Senior Research Associate

acting as recorder, observer and analyst of the data. This was done in order to utilise the

I think it is something people say when they don't want to understand, are lazy, protecting their territory or just want to keep on in their own world.

insider connection that Chief Investigator A had with hospital-based clinicians. These field staff were also assumed to be more likely to respond to an evaluator with equal status. In the fifth focus group, with DHS Senior Executive staff, using the Chief Investigator A to conduct the group offered some measure of protection to the Senior Research Associate as a seconded employee of DHS.

The field participants expressed the view that they were weary from what appeared to them as an unending cycle of sometimes contradictory reforms that were often not fully implemented before being overtaken by other waves of reform:

There is no cumulative corporate memory. Each time you have a reorganisation, you have to teach the whole bloody stuff all over again. It drives me barmy... If anything makes me angry about the whole deal it is this failure to learn and having to invent the bloody wheel again and again. I've been around for 30 years and I reckon I've seen it at least seven times during that time.

This continuous reform was seen by the field participants as leading to increased cynicism and low morale in health system staff:

There is a growing gap in understanding between staff and managers ... this results in decreased innovation, demoralisation, staff are unaware of policy changes and changes imposed on management.

The participants also expressed the view that many reforms were imposed from the centre without taking into account their effects on the ground and that in pursuing integration of health,

housing and community services, the Department had marginalised health as an area of concern:

We don't have a health department, and out of the latest DHS reorganisation, the super-department, you now don't mention the 'H' word. I mean health in the department is almost a dirty word.

The field staff felt that the central bureaucracy had given mixed and unclear messages about the directions and methods for integration of health, housing and community services:

What seems to have been built in is a much higher degree of uncertainty because there seems to be this intent to change but no one seems to have been close to identifying in what direction ... at the moment there are all these interminable reviews going on and where is it all going at the end of the day?

and that health professionals' knowledge and expertise were ignored in the process.

... anybody with clinician on their forehead are people you mustn't talk to because it will distort your decision-making.

The DHS Senior Executive focus group

Results from the four 'field' focus groups (with all quotes de-identified) were compiled into a discussion paper and sent to the 'centre' participants in the final focus group. The questions they were asked to consider in their focus group were:

- How important do you see the role of DHS in promoting and supporting integration and collaboration between human services?
- What is your vision for integrated care for human services? For health services?
- What key policy and practice changes are needed to achieve this?

The responses of this group to the concerns raised in the field focus groups included that the complaints of lack of consultation by clinicians reflected the fact that they were narrow in focus and reluctant to take on board a wider integration agenda:

When I talk with clinicians often, and the more senior they are the more I see it, it is that they come from a very narrow perspective and get very frustrated when you try and work and link in some of the other things.

DHS senior executive staff felt concerns expressed by the field about health being marginalised within the Department confirmed their view of clinicians' reluctance to change and move in the new directions:

You make the point somewhere in there [the discussion paper] about the de-medicalisation or taking clinicians out and I wonder if it is really that they are not comfortable with the broader picture rather than they are actually being taken out of it.

They also believed clear directions for the field had been provided and that this complaint was an excuse to avoid changing outdated structures:

I get a bit impatient with it because I actually think it is an excuse for people not getting off their backsides and doing something ... using structures to deliver outcomes. I think it is something people say when they don't want to understand, are lazy, protecting their territory or just want to keep on in their own world.

As is often the case, the results from the field focus groups led to criticism by some Senior Executives of the evaluators as the bearers of bad news and of the action-research methodology chosen for the evaluation.

Benefits and risks of the outsider evaluator with insider links in a turbulent environment

It was evident from the results of the focus groups that a difficult relationship existed between the centre and the field at that time with each contributing to a culture of blame perpetuated by feelings of uncertainty and a lack of clear direction. Staff from the field perceived that their expertise in service provision had been ignored in the formation of new policy directions. The central bureaucracy perceived health care agency staff as resistant to change and as obstructing integration efforts. There was also a suggestion that in documenting these concerns, the evaluators were giving unfounded credibility to the field's grievances. This culture of blame also meant that opportunities to learn from and reflect on past change efforts, both successful and unsuccessful, were not taken up.

The results from the focus groups were further reinforced by feedback the evaluators were receiving informally from both other workers in the field with whom they had contact and from non-Executive level staff within the central DHS office. On returning from her secondment, the Senior Research Associate found that the organisational climate of the central bureaucracy appeared dominated by anxiety and uncertainty and that people felt unable to voice any concerns or critical views about current policy directions for fear of ostracism or being scapegoated. This atmosphere made her dual role as an employee and evaluator a double-edged sword. On the one hand she had access to information that could enhance the evidence being collected by the evaluation on the centre/field divide and on the other hand, she felt the dangers of publicising too widely these emerging findings. As an employee of

DHS, she risked being marginalised for reporting results that were perceived as critical of the organisation (DHS).

Risks also existed for other members of the team such as the Professor of Public Health (Chief Investigator A). Her role as Director of the DHS-funded community health research unit meant she and the unit were vulnerable to having that funding reduced or removed. The field based CEO (Partner Investigator) involved in the evaluation also risked being marginalised by the central bureaucracy that funded his agency.

This provides an illustration of how an evaluation team that has members with both outsider and insider roles can be both enhanced and complicated by this combination. The Senior Research Associate, as the most vulnerable member, dealt with these tensions in a number of ways. Following her return to her substantive position in DHS, she stressed to all participants that she was carrying out this evaluation as an employee of the university, acting separately from her role within DHS. All evaluation project work was done on the one day per week set aside and at the university department. Extra care had to be taken to de-identify all comments reported from the focus groups and to assure confidentiality to those involved. It also meant ongoing concern from the Senior Research Associate about the reaction of the DHS hierarchy to the presentation of results from the evaluation at conferences and in published papers. The dilemma of reporting findings openly versus protecting those who have provided frank feedback was also acutely felt in this project. The health system in Adelaide is a small one and it would be possible for some comments to be traced back to the source, even when de-identified. In addition, there is the ethical obligation of

evaluators to honestly report their findings to both funders and stakeholders

(Weiss 1998), along with the need to add to the knowledge of an under-researched field. The evaluation team felt that as a matter of ethical integrity and principle, this consideration should be uppermost in decision-making even when there are perceived or actual threats to the career or funding of the organisation from which the evaluators come.

In addition to these issues, there was significant trust shown in the evaluation by the field focus group participants and we would attribute this openness to a number of factors including:

- respect for the university as an institution and the project investigators as individuals
- the responsible handling of sensitive information shared with the evaluation team in earlier data collection exercises

... people felt unable to voice any concerns or critical views about current policy directions for fear of ostracism or being scapegoated.

- feelings of identification and understanding through the use of the developing discussion paper with the focus groups. Participants expressed their appreciation of this paper that provided a context for understanding the continuing waves of reform and identified consequences and concerns that struck a chord with them (see van Eyk & Baum 2003, forthcoming). They clearly believed the evaluators understood the complexity of the situation
- the opportunity to voice their concerns to the department without being personally identified in the process. Some participants felt the focus groups were a way of raising those issues that they had been unable to voice as individuals, believing the Department did not see their concerns as legitimate
- the opportunity to see the finished report on the focus groups and provide feedback
- the Chief Investigator's role in conducting the focus groups. She was perceived to have equal status with managers and senior clinicians and this added to the evaluation's credibility.

Interviews for the Southern Managers Forum

The second example of the overlap between insider knowledge and outsider objectivity arose in the process of evaluation of the Southern Managers Forum, which was part of the broader Health Care Reform in Southern Adelaide Evaluation Project. This evaluation involved two rounds of semi-structured interviews (December 2000 and July–August 2001) conducted by the research officer with managers of southern human service agencies, and middle managers from DHS. These two groups were involved in a joint monthly management forum to discuss regional planning and possible co-location of community based services. This forum, initiated by DHS, had already been in operation for a year before the evaluation was commenced. The evaluation team suggested to DHS that the Managers' Forum could be included as a case study in the Health Care Reform in Southern Adelaide Evaluation Project as an example of the new policy direction of integration and as a way of offering its expertise to the centre. It was also hoped that a useful evaluation of this forum would result in the overall project being viewed more favourably by the department.

The Research Officer interviewed all participants in the Management Forum (13 agency managers and five DHS officers) about its aims, achievements and difficulties on two occasions, eight months apart. The first round of interviews suggested that the centre/field conflicts found in the focus groups were also present to some degree within this group. The initial months of the evaluation were characterised by observed tension between the two

groups and a reluctance to be open about their concerns. The results of the first round of interviews confirmed this observation. Agency managers described themselves as cynical about the department's motives for pursuing integration and the likelihood of it succeeding without significant funding and other resources.

I think they're [DHS] also looking at trying to reduce costs. While that may happen in the long term, to truly integrate different agencies would cost a fortune in the short term.

They also described a feeling of being unable to criticise the department's directions for fear that it would have an adverse effect on their subsequent funding.

I think there are people who come to those meetings who are not necessarily committed and so energy and enthusiasm is low ... some people are uncertain about whether they want to be part of it or not but they don't want to be seen to not be a part of it.

By contrast, the centre-based managers, like their Executive counterparts in the focus groups, felt that the biggest obstacle to achieving integration was what they described as 'turf guarding' by the agencies.

I think the barriers will be what they always are, which is the nature of organisations and competitiveness and a sense that 'So are we gonna have a job or are we gonna be ...?'; or 'It's all too hard'; or all those things where people get into it. So you've got a lot of professional interest which we need to work through.

In order to make the evaluation a meaningful and useful process for all parties, the Research Officer needed to establish mutual trust and cooperation. Unlike the focus groups, which formed part of a longer term evaluation exercise, this trust had to be built up from the start. This was achieved in a number of ways:

- In line with the action-research approach, the Research Officer sought input from the group at every stage of the evaluation including drafting questions for the interviews, along with offering the results in draft form to each group member before they were formally compiled into a report.
- Assurances of confidentiality and de-identification of any quotes used from the interviews.
- Providing careful explanation of the reasons for the evaluation, its external nature and that of the Research Officer, stressing the role of the university in conducting this project.

- In the case of the agency managers, the Research Officer referred to her previous role as a practitioner in one of the local agencies when introducing herself and thereby suggested that she had some understanding of the issues and difficulties facing community-based services.
- The Research Officer's role as an outsider to the forum was maintained. She did not participate actively in forum meetings other than in reference to the progress of the evaluation. She became aware from the first meeting of the need to be seen as a neutral party in relation to the centre/field tensions that were evident.

Success of these endeavours became apparent in the second round of interviews in which it appeared that the field and DHS managers had developed greater trust and more common goals than had been expressed in the first round. The participants attributed this change in part to the role the evaluation had played in bringing everyone's concerns to light in a non-threatening and constructive manner. Also, trust had been developed as a natural consequence of a longer period of working together.

Discussion

In summary, the experiences of the evaluation team in conducting this project in an atmosphere dominated by tension and conflicting perspectives between the centre and the field provides some important lessons for those seeking to utilise both insider and outsider evaluation expertise. In the case of the Health Care Reform in Southern Adelaide Evaluation Project, the team was predominantly outside the processes being evaluated, but each member had either past or current links to the stakeholders that afforded them a measure of insider status. As has been shown, this was both a blessing and a curse. The evaluation team members were able to utilise their positions as predominantly outsiders to assure participants of the confidential nature of their input. They also benefited from their affiliation with an external institution – the university – and could avoid potential accusations of bias through the reputation for ethical and even-handed research by the investigators. One risk of a purely external evaluation was that it would lack access to important information such as the impact of health system reforms on the work of individuals that could add to the understanding of the data being gathered. It could also potentially heighten the tension between the centre and the field and unwelcome findings would be ignored, resulting in wasted effort and increased cynicism among those who had contributed to the process. Outsiders could also be accused of not fully understanding the system, discrediting their evaluation findings.

The evaluation team benefited from having insider views on how the processes of reform were being formulated and received both in the centre and in the field, and from the historical knowledge

provided by field participants about previous initiatives. This knowledge also enhanced the credibility of the evaluators in that the field participants felt their concerns were understood and that their information would be treated with respect. The status of the Chief Investigators meant that the evaluators had equal footing with the clinicians and the central Executives. The flipside of this was that the risks of being associated as a partial insider with a controversial evaluation were high. The centre had the power of funding and employment over most of the evaluation team and there was a very real risk that unpopular findings could have negative consequences for those involved. In recent years there have been reports of organisations losing access to government funding after voicing criticism of government policy. For example, in 2001 *The Australian* newspaper described the cases of several non-government organisations that were de-funded by the federal government after publicly criticising aspects of health care funding or policy (Kerin in *The Australian*, 28 May 2001). Also, the evaluators needed to be mindful that their field informants were vulnerable to this possibility and needed to protect their anonymity.

In building sufficient trust from both sides to enable the evaluation to carry out its objectives, the following strategies proved useful:

- careful handling of information over the life of the project
- regular feedback of interim findings to key stakeholders
- use of methods that were responsive and dynamic including action research, the developing discussion paper for the focus groups and semi-structured interviews
- consultation with stakeholders and taking on tasks that were identified as being of use to them in planning while maintaining the focus of the evaluation
- use rather than abuse of insider roles and clear distinction between these and the external nature of the evaluation where possible
- attempts to leave the setting with positive feelings about the evaluation among all stakeholders.

This last point had relatively limited success in that Senior Executive staff from DHS largely felt the evaluation was irrelevant as the focus of policy had changed from their point of view (expressed in their final report on the value of the evaluation to them as industry partners). However, the process evaluation of the Southern Managers Forum was

It was possible that unwelcome findings could have been ignored or worse, used to marginalise or penalise the evaluators.

accepted as being useful by the section of the department responsible for its initiation and implementation.

In contrast, the field-based workers did find the evaluation useful in that it helped them to better understand the changing context in which they were operating. Subsequent policy makers (appointed following a change of State Government in February 2002) have submitted the evaluation report to the current Generational Review of South Australia's Health System. The new CEO of DHS described the report as one means of facilitating organisational learning processes in the department, something he was promoting actively. It is notable that changes in health systems policy are so frequent that these results, unpopular with the previous policy makers, are now considered valuable and useful by the latest appointees.

Conclusion

This article has shown how a combination of insider and outsider evaluators can bring both benefits and risks to a complex project, such as the evaluation of health system reform. The ability to use insider knowledge in an evaluation conducted under the auspices of an external body greatly adds to its credibility and comprehensiveness. It also aids with the building of trust between evaluators and stakeholders, which in turn helps foster frank discussions. However, these same insider links can also pose risks to evaluators and some informants. The evaluation team for the Health Care Reform in Southern Adelaide Evaluation Project enjoyed the benefits of experienced policy and organisational operators. These skills were essential to ensuring the project continued through difficult organisational and political times. It was possible that unwelcome findings could have been ignored or worse, used to marginalise or penalise the evaluators. In such a context, measures such as balancing insider knowledge with outsider objectivity and ensuring that the evaluation remains rigorous, meaningful and ethical in its data collection and reporting are essential. Use of these measures, can maximise the benefits of an insider/outsider team while minimising the risks. Effective use of this team

composition can also increase the chances of a useful and meaningful evaluation process and outcome for all involved.

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