



Inside this Issue

Management careers in health	1
Health in the News: Risk, Reporting and Media Influence	5
New Committee elected at Branch AGM	6
Upcoming events	6

Management Careers in Health

"A career in health management requires a very special kind of person because Health Managers work in a sector that has far greater complexity than any other," said Graham Ewing, Principal of EQI Global in the course of his informative and sometimes challenging presentation to our October seminar meeting. Graham believes that in New Zealand we lead the world in health service management but we just don't say so.

Graham is well placed to comment, having been involved in high profile executive search and recruitment for more than 18 years. His assignments have involved appointments of Company Directors, Executive Directors, Chief Executives, Senior and Executive Management. These appointments have been spread across a broad number of industry sectors and include both large and small private companies and Government-owned enterprises. In the public health sector, Graham has been involved in the appointment of Chief Executives to most of New Zealand's District Health Boards.

Graham noted that health management is very different to management in most other sectors. The health sector is dynamic and complex, with distressed clients, the tension of 24-hour delivery, limited resources and exposure to constant public and political scrutiny. The sector is one with continual technological advancement; the workforce is the intellectual 'cream' using an international language, and it has a high community profile with an oversupply of business.

Over the last 20 years health care systems have undergone major reforms. Health Managers now have responsibility and accountability for the total population. The emphasis has shifted to primary and community care and trying to keep people out of hospital. Advances in medical technology, an aging population, the increased complexity of chronic diseases and changing morbidity patterns has increased demand and community expectations, and escalated health care costs. This is taking place in a political environment where Institutional care has become too expensive and Governments are demanding value for money, using a commercial model with benchmarking and comparisons. This creates huge pressures on health systems, structures, and staff operating in a cycle of constant restructuring.

Until the 1980's, the public health system had a static organisational structure with clearly defined roles for a triumvirate of Medical Superintendent, Matron and Hospital Administrator. There were few initiatives and little attention paid to the changing needs of the community, or accounting for the utilisation of resources. Now, we are in an era of constant change (which along with taxes and death) are the only certainties. There is legislated democracy and centralised control, where the Government says the community has the funds, so they can distance themselves from responsibility, yet retain a highly prescribed national health strategy. This is not necessarily wrong but it puts a Health Manager in a difficult situation as he/she is directed centrally but expected to listen and respond locally.

There is now another layer of governance with elected Boards and Committees.

(Continued on page 2)



Graham Ewing



(Continued from page 1)

Some elected members have little health or managerial experience and often have their own agendas. There have been several cycles of Chief Executives, the first with a very commercial focus, General Managers and Clinical Leaders; regular restructuring and a range of imperatives with a commercial model to improve efficiency, productivity and quality.

With the shift of attention to population health strategies, the role of the Health Service Manager has expanded and become broader and more complex. The focus is more output orientated with emphasis on economic efficiency, performance measures, and both the quantity and quality of services delivered. Managers have closer working relationships with policy makers, clinicians and consumers. They are required to advise policy makers and Corporate Boards, have expanded responsibilities for some clinical staff, and an increasing ethical mandate.

Today's Health Service Managers require new skills. Human resource management, organisational capacity building, strategic management, quality management, risk management, clinical governance, information management, contract management, community consultation and participation, and public relations, all become more important.

There have also been role changes with Clinicians moving into management or working in partnership with management. Now we have different models of service delivery, such as pathways and integrated care. This places huge pressure on Health Managers to define the processes that deliver effectively and efficiently and will achieve all the other imperatives of productivity and quality. The removal of layers of Middle Managers has resulted in some General and Senior Managers having 20 to 30 direct reports. That's crazy, but you have to work with it.

So what is the future role of the Health Service Manager. It is one of increasing complexity with greater use of technology. With the increasing trend of specialisation, there is further division of labour, which brings a challenge to remain human centred and connected, whilst improving co-ordination and integration. Not only do Health Managers face pressure to ration resources, they are accountable for high quality service delivery in an environment with an accelerating rate of change. They are expected to function both operationally and strategically, and in doing so, consider the impact of the wider organisation at a time when there is less time to plan. Increased complexity reduces the ability to predict the future without appropriate analytical tools and information. This places limitations on the capacity to forecast and strategically manage. Do we have the body of knowledge? If not, are we researching and developing a body of knowledge in modern health service management science in order to address a lot of these things? Perhaps this is an area that is not being addressed as well as it should be.

What are the competencies required for senior and middle management in health? Besides specialised knowledge, what are the criteria Health Managers might want to measure themselves against? Looking at the subject generically, the competencies can be broken down in to a number of groups.

First, a commitment to achievement. Breaking this down a bit, a personal commitment to excellence and a focus on attaining organisational goals and objectives; flexibility and adaptability; an ability to initiate action, with drive, enthusiasm, determination, tenacity, and a persistence to achieve. An ability to prioritise tasks and deliver whilst maintaining a balanced life is also important. Charisma and being 'nice' does not do it in this sector – you soon get found out.

Second, honesty and integrity. There is huge pressure to compromise when you have to ration and make decisions, so there is a need for people with an ability to model the highest standards of personal, professional and institutional behaviour, with honesty, commitment, loyalty, maturity, and high ethical standards. Along with this must be a willingness to accept responsibility, be consistent, make hard decisions, and be self-critical.

Third, intellectual capability. This is absolutely crucial in the health sector. As senior and middle management progress through the system, the complexity of the tasks increase and the intellectual capability of professional and management colleagues also rises. Therefore, there is a need

Fourth, communication skills. This is also crucial in the health sector. As senior and middle management progress through the system, the complexity of the tasks increase and the communication skills of professional and management colleagues also rises. Therefore, there is a need

(Continued on page 3)

Differences in the roles of Clinicians and Health Service Managers

	Clinician	Health Service Manager
Tasks:	Clear Consistent	Ambiguous Fragmented and varied
Role	Well understood Respected	Poorly understood Challenges to Authority
Relationship	Limited	Wide network
Orientation	Patient	Organisational
Thinking	Systematic	Ad hoc, incremental, intuitive
Decisions	Rational	Political, Resources
Skills	Clearly defined	Organisational skills ill defined & Varied



(Continued from page 2)

for people who value and apply intellectual processes and quickly grasp and assess complex ideas to arrive at innovative and well reasoned solutions that take consequences into account.

Fourth, skills in leading and managing people are important. The ability to get things done by motivating and empowering people to achieve organisational goals and objectives.

Fifth, managerial expertise. This is an area that is sometimes undersold. An ability to develop the sort of processes that are probably only relevant to health organisations. There is often a tendency to put in performance management, selection, or quality programmes that are grabbed from elsewhere but are not nearly as effective in this sector. Graham believes there are a range of general management principles available and he certainly would be looking to the academic sector to develop specialist management processes and techniques relevant to public health.

Sixth, effective communication. Clear and effective two-way communication with a diverse range of people and situations is required in order to explain, persuade, convince and influence. This has to be done rather subtly because Health Managers often do not have the authority to direct. That is where the intellectual capacity and integrity is all packaged together to enable a Manager to make real impact. Because health has such a large core of people, the Health Manager must be able to constantly build and sustain relationships to connect with people at all levels across a variety of organisational settings and community interest groups.

Seventh, strategic leadership. The whole concept of strategic leadership is a relatively recent development. We are looking for people who can do things in a realistic way, as well as think innovatively and communicate with and inspire staff.

The last generic area is managing, in a political/cultural context. The high expectations of the community and Politicians are central for Health Managers. They must know when to say something and when not to. This requires a good understanding of central Government policy in order to avoid the often harsh political clobbering machine.

So what of health management as a career? Do we promote it as a career option in our Secondary Schools and Universities? Graham suggests that it is not. You can go off and do a Masters Health degree at Auckland University or the University of Otago, but we do not promote it as a career. It has only come on the scene in the last ten years, as New Zealand has developed a structure that recognises the importance of health service management. Graham thinks we are doing it a disservice by not promoting it as a real career opportunity that has come of age. This is a huge area of employment and we miss the boat by not attracting the 'cream'. The Medical School attracts the 'cream' but we are not doing enough to give health service management the status it deserves.

Do we need some sort of buy in between practical experience and academic training? Certainly in the United Kingdom that is the way it is done. Although they have more fat in the system, maybe now is the time when we have to encourage it. Do we need to formalise linkages with Australia, Canada and the UK since they have sophisticated public health systems? Currently people do not deliberately commence health management as a career. They come in to it from being Clinicians or Financial Administrators etc and get there eventually, more by accident than design.

What do we do with those people who do not make it to the top job? Health is a sector that can be brutal on its people. We are a very small Country and it almost depends upon who is in fashion with the key influencers. It is a very serious issue for us. People at the first, second and third tier levels are known and get talked about. Health management, as a profession, needs to do a lot of work to promote and publicise itself and put support around its people to establish just what is happening when things are going wrong.

Do we lack specialised qualifications for Health Managers? There are few specialised programmes, yet there is a great opportunity for our Universities to attract people to New Zealand to work in a health system and do a Masters Health degree in a Country that Graham suggests is a little more sophisticated, mobile, and autonomous than some of our modern neighbours. We have the opportunity to promote a world leading Masters Health degree but it does need to be based on research and not cobbled together. That means some of our academics need to do some homework.

Clinicians are very evidence based in their practice. Is our management practice evidence based? Graham suggests that if we were able to develop health management as a

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(Continued on page 4)



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science we would remove some of the blame culture in health. This culture is all about subjectivity because we don't know what to measure; and we don't have the tools or equations that will give us the hard data for evidence based answers. If we have these we might attract more respect from our Clinicians and that would remove a lot of the tension between them and management. There is, therefore, a very powerful case for New Zealand to develop a world leading Masters Health Management degree.

Is health management seriously promoted as an option in Medical Schools? When Graham asks that question of Clinicians that he has interviewed for management positions, most of them say a health management career was never considered. Why would it be? Yet a career in health management would offer continued variety and challenge.

Those involved in recruiting at the Senior Health Manager level are constantly asked, "Is health sector experience necessary or not?" Although Boards and Chief Executives might initially want to consider candidates from a wide number of disciplines, as the field narrows, previous experience in the sector appears very important. The majority of Health Managers have previous health sector experience. There are advantages and disadvantages in selecting Managers with previous experience. If we don't consider people with a greater variety of backgrounds, we run the risk of not innovating and challenging accepted practices.

A high level of complexity is common in health organisations but less so in non-health organisations. There is the potential and tendency, when looking for people at a senior management level, to look for those who have worked in large complex organisations. Of course, now with globalisation stripping the world of large complex organisations, at least in Australia and New Zealand, this is not a very fertile field in which to look. Despite this, are we too limiting in our selection criteria and do we accept and encourage management diversity? Is health management a closed shop? If it is, we had better make sure we are attracting young people into it, motivating them, and showing them there is a career here.

However, we have to be a little cautious about career path planning. Can we actually deliver on a career path? There is only so much career path planning you can do because the reality is that we are in a dynamic world that is changing rapidly and it is very hard to forecast. It is up to the individuals to go out, knock on doors and demand more of their organisation and of themselves. It is up to each one of you when you are ready to move to show drive and energy. Are you prepared to put yourselves at risk and personal cost? Are you mobile?

Health Managers work in a sector that has far greater complexity than any other organisational sector. It is hugely demanding and stimulating, and a great career choice. We need to do more about publicising health management as a serious career option and establishing it as a true profession. New Zealand is a leader in innovation, although we do not hold our hand up and promote it enough. Have we developed the science of health management?

The choice is yours!



There was standing room only for this presentation

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HEALTH IN THE NEWS

Risk, Reporting and Media Influence

A King's Fund report, 'Health in the News: Risk, Reporting and Media Influence', has criticised journalists for hyping up new health scares to sell papers, rather than concentrating on the major killers such as tobacco-related diseases, alcohol, obesity and mental health. Lesser risks, such as the MMR vaccine, vCJD, Aids and alleged crises in the NHS, command column inches in excess of the danger they represent. There are fears that this unbalanced reporting will lead to the Government being pressed to spend public money unwisely in response to dramatic but statistically insignificant issues in the news. If journalists reported risk proportionately, smoking would have made the health headlines for decades. If nothing else, the report provides solid research data supporting New Zealand health managers' common belief about our media. A summary of the report is available at www.kingsfund.org.uk/summaries

Major reporting of health related news stories can be highly influential: the priorities and decisions of policy makers are often shaped by what they see on television, hear on the radio, and read in the general and specialist press. Members of the public may alter their behaviour, in ways that affect their health, at least partly as a result of information and advice they get from the media.

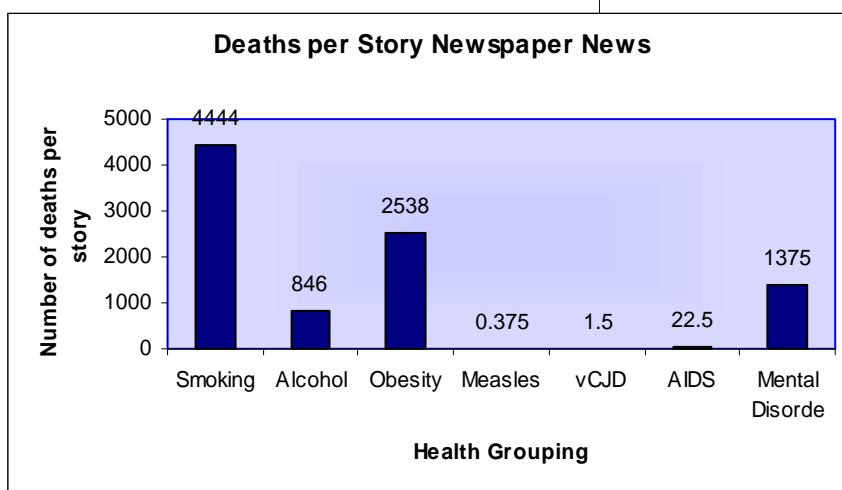
The news media tends to focus on stories about health services. Only rarely do they publish stories about public health – that is, measures to improve health, prevent illness or reduce health inequalities. Public health specialists find it infinitely more difficult to cultivate media interest in serious proven health risks, such as smoking, alcohol and obesity, than in, for example 'crisis in waiting lists'. Meanwhile, unusual hazards such as SARS, which pose relatively little danger, can occupy the headlines for weeks on end.

The study, conducted by Roger Harrabin, a leading correspondent with the Radio 4 Today programme, and supported by the Kings Fund, explores the causes and significance of the apparent imbalance in media coverage of health related issues. Harrabin and his co-authors, Anna Coote, and Jessica Allen, were not interested merely in accusing the media of exaggeration or misrepresentation. Nor do they suggest any simple causal link between patterns of reporting on one hand and policy decisions and personal behaviour on the other. The study's intention was twofold: to air a debate that has so far been largely confined to academic circles; and to raise awareness - on all sides – of the experience and views of public health experts, policy makers, reporters and editors. Both aims are part of a more ambitious goal, which is to shift the emphasis of the policy agenda, so that it gives higher priority than it does at present to public health targets – improving health for all and reducing health inequalities.

Three questions lay at the heart of the inquiry. To what extent does news coverage of health related issues reflect mortality risks shown in health data? If the balance of health news coverage is seriously out of proportion with actual risks to health, how much does it matter? Can and should anything be done about it?

The inquiry explored the views of public health experts and health policy makers; analysed news content in selected media outlets; considered the balance between reporting dramatic stories, such as 'hospital crisis' and 'major health scares', and less dramatic issues that statistically have a greater impact on health. Reporters and editors were then asked for their perspectives on the findings and why some stories are more worthy of attention than others.

Not surprisingly, most public health experts and health policy makers interviewed were unhappy with the way health issues were covered in the news media. Most said they wanted more balance in the news coverage and expressed a preference for reporting by specialist journalists who, in their view, had a keener understanding of the issues. In common with most experts, they also wanted their knowledge to be aired more widely and frequently in the news media.



(Continued on page 6)

(Continued from page 5)

In all the news outlets studies there was a preponderance of stories in two categories. One was the NHS – mostly stories about crises besetting the service nationally or locally, such as growing waiting times or an increased incidence of negligence. The other was health ‘scares’ – that is risks to public health that were widely reported but which often involved little empirical impact on rates of impact or premature death. Themes that invariably received very little news coverage included preventive health measures and major health risks such as smoking and alcohol.

The study went on to compare the volume of reporting on specific health risks with numbers of deaths attributable to those risks. The resulting ‘deaths per news story’ is a crude measure designed to provoke debate. Put simply it measures the number of people who have to die from a given condition to merit a story in the news. It shows, for example, that 8,571 people died from smoking for each story about smoking on the BBC news programmes studied. By contrast, it took only 0.33 deaths from vCJD to merit a story on BBC news.

Does this matter?

Members of the public interpret media content in different ways, at different levels, and their interpretations vary according to the nature of the material. Nevertheless, the report’s authors suggest that there are at least three reasons why it may matter if the news media give a disproportionate picture of what public health experts consider to be most important and urgent in health terms.

First, there is evidence that some kinds of media coverage of some health issues make an impact on public behaviour. For example, parents refusing to let their children have a combined MMR vaccination after media coverage of a lone scientific paper linking the MMR jab with autism. Arguably, this is a case of media coverage affecting public behaviour in ways that may increase rather than reduce health risks.

Second, the authors have a view, shared by the newspaper interviewees, that policy makers sometimes take their cues from the media. It is not uncommon for politicians to assume that the media reflect voter opinion, or prefigure it by running campaigns to influence sections of the electorate. In response, politicians issue a new promise, introduce a policy alteration, or change current priorities or spending patterns.

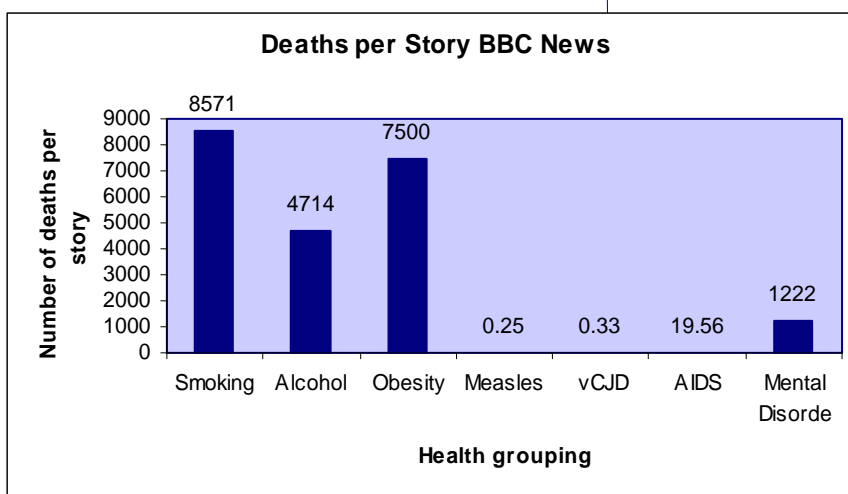
Third, government priorities and spending patterns influence media agendas and public attitudes in ways that are sometimes mutually reinforcing. For example, if a preponderance of news about people being kept waiting for NHS treatment prompts the Government to give higher priority to reduce waiting times, and to issue new targets in this front, it may encourage some media to redouble their efforts to find stories about people being kept waiting (and specialists to give them stories?) This is one way in which the media can quite legitimately hold the Government to account. But the more headlines there are about waiting times, the more anxious people will become about having to wait for health services, and the more tempting it may be for the media to find stories that reflect and feed that anxiety. Policy makers, in turn, may come yet under more pressure to reduce waiting times. Resources may be invested accordingly – at the expense of other health related initiatives that bring greater benefit at less cost.

Could things be different?

The authors state the purpose of their study was to open up debate. They offer a number of initiatives that might encourage a closer fit between risks to public health and news reporting. They believe there needs to be:

- More openness amongst journalists about the construction of news and its potential impact on policy-making, public opinion and behaviour.
- More consistently robust handling of data analysis by news media – particularly by non specialist journalists – in accessible terms, to help lay audiences put risk into perspective.
- A better understanding among public health protagonists about how news is constructed

(Continued on page 7)





**New Zealand
Institute of Health
Management
A Branch of the
Australian College of
Health Service
Executives**

For all inquiries re Branch activities or membership contact admin@nzihm.org.nz or (09) 577 5477 Phone/Fax



Up coming Seminars

November 5th

@ Brightside Hospital
Brightside Ave, Epsom
5:30p.m. for 6p.m.

Getting Maximum Value for your IT Spend

Anne Hall, Principal, IT LAW

Non Members Welcome

Cost

Members \$20

Non Members \$25

This will be the last seminar for 2003. Don't miss out.

Refreshments will be supplied by:



(Continued from page 6)

and the imperatives and constraints under which news outlets operate.

- Greater awareness on the part of policy makers that intense news coverage of a particular story may not necessarily reflect public opinion nor convey an accurate picture of risks to health.
- A better understanding by experts, policy makers and the media of how the public perceive and interpret health risks.
- A more mature relationship between Government, experts and citizens, based on informed dialogue and mutual respect, so that the risks can be discussed and negotiated openly.
- Stronger advocacy for public health issues at national, regional and local levels.
- More debate about the role of public service broadcasters in shaping news agendas and influencing policy and practice through news reporting.
- A greater readiness to track patterns of risk reporting over time.
- More skilful presentation of health issues by experts and policy makers for news and feature outlets, with the attention to the need for accessible language, and for sound and pictures for radio and television.

Don't look for any sudden change in the way health is reported in the media. For example, the eight stories in the BMJ summary of media stories for the 21 October were:

- * Scientists hope to end flu misery within five years;
- * Virulent flu variant is on its way to Britain;
- * The pill that prevents DVT;
- * The 12-minute cure for chronic backache;
- * Bee-venom therapy to treat auto-immune diseases;
- * Spray-on foam that eases psoriasis;
- * Light treatment can beat PMS; and
- * Drug reduces risk of prostate cancer

The media hyping this week of the orthopedic bed debate at Auckland's new City Hospital provides a perfect illustration of the report author's views.

Our November seminar speaker, Anne Hall established IT LAW in 1999 and has practiced almost exclusively in IT and telecommunications law since early 1993, becoming one of New Zealand's most experienced IT lawyers. At IT LAW, Anne provides specialist legal advice on a broad range of IT, e-commerce and telecommunications matters, with an emphasis on advising on strategic decisions in the relevant business context. Anne regularly presents seminars to business and university groups on a range of information technology law topics.

New Branch Committee Elected

A large group of members, perhaps attracted by Graham Ewing's presentation, gathered for the Auckland Branch AGM. Chair, Trisha Ross conducted the business of the meeting with great efficacy. We congratulate those who won election to the Branch Committee and thank unsuccessful candidates for offering their services. As Graham mentioned in his address, we are in a dynamic sector - good managers are mobile. They show drive and energy and move on. There may well be casual vacancies through the year as people move on in their careers.

Your new committee is:

Trisha Ross	Chair	
Ian Wolstencroft	Secretary	
Alan Johns	Treasurer	
Sue Frost	Vic Middlemass	Donna Neal
Bruce Parkes	Jackie Richardson	Fiona Ritsma
Sue Shipperlee		