



Population Aging and Future Hospital Demand

Along with other countries in the 'developed world' the gradual aging of our population is a constant theme permeating a wide range of contemporary health and welfare policy debates in this country. With the leading edge of the baby boom generation now turning sixty and the increasing life expectancy of still earlier generations, there is a general assumption and acceptance of increased welfare dependency and health care costs. The aging of the baby boomers is often raised as a justification that cannot be disputed. Yet while few would dispute that aging will increase the demand for hospital services, previous research has suggested that in fact the magnitude might be small in relation to the overall trend.

A new study by Bradley C. Strunk, Paul B. Ginsburg, and Michelle I. Banker, published in *Health Affairs* 25 (2006), seeks to build on previous research on the effect of population aging on hospital use by examining how aging will specifically affect demand for inpatient services and how this impact will vary across medical conditions. While the analysis is US based the broad findings would seem to be applicable in most developed countries. The analysis examines how shifts in the age distribution of the U.S. population, reflecting both the aging of the baby-boom generation and increased longevity, will affect demand for hospital inpatient services during the next ten years. Over that period, aging will drive about 0.74 percent annual growth in use of services. Aging's effect on inpatient demand varies by medical condition, with the highest rates of growth in services most used by elderly patients. Even for those services, however, aging is a much less important factor than local population trends and changing practice patterns attributable to advancing medical technology.

The study predicts how changes in the age distribution of the U.S. population will affect the future use of hospital inpatient services, all else held constant. It seeks to isolate the effect of population aging (taking into account accepted assumptions about future fertility, mortality, and immigration) from other factors that could affect hospital demand.

The study focuses specifically on inpatient hospital use. Although a study applicable to hospital outpatient settings would also be valuable, such a study would be limited by data availability and by the uncertainty of the outcome of the growing competitive battle between hospitals and physician-owned facilities, such as outpatient surgical centres, imaging centres, and physician offices, which provide increasingly more of the ambulatory tests and procedures received by U.S. patients.

The most precise measure of outpatient use is a count of outpatient visits. Because a count of visits does not distinguish between services requiring few resources, such as a visit for primary care, and those requiring extensive resources, such as complex imaging, it was not considered very useful for the analysis. Since the use of inpatient services varies more by age than use of hospital outpatient services does, the study was limited to inpatient services to gain a higher estimate of the impact of aging than one that covered all of hospital care.

The authors first calculated the per person utilization rate for people of each age up to eighty-five (all people age eighty-five and older are grouped together) using the 2003 NIS APS-DRG relative charge weights and total number of discharges and U.S. Census Bureau population projections for 2003. Second, for each age, they multiplied their calculated utilization rate estimate by the total number of people of that age in a given year as reflected in the Census Bureau population projections, giving a projection of total use for people of each age in that year. Third, they summed the projections of total use by age and divided by the total

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projected population, giving a simulated estimate of utilization per person for the entire population in that year. The procedure was repeated for each year in the study period, holding the utilization rates per person constant throughout, and the change was calculated from one year to the next. This change represents the effect of shifts in the age distribution of the population, holding all other drivers of hospital demand constant.

They then compared this estimate to the Centres for Medicare and Medicaid Services' (CMS's) projected change in total inpatient hospital spending for the period 2005–2015. Although the CMS has not released projected data for inpatient revenue alone, they calculated past trend differences between inpatient and total hospital spending and assumed a continued differential.

Study Findings

The effect of aging on hospital utilization—or any other measure of utilization or spending, for that matter—will be driven by two factors: the rate at which the age distribution of the population is shifting toward older ages, and the rate at which utilization increases with age. Despite popular conceptions, the age distribution of the population shifts very slowly from one year to the next; between 2005 and 2015, the average age of the U.S. population is projected to increase from 36.5 to 37.9—an average annual increase of 0.37 percent. This slow growth in the age distribution of the population limits the magnitude of the impact on utilization.

Based on the methodology discussed above, the study simulations indicate that from 2005 to 2015, per person inpatient resource use will increase by 7.6 percent because of aging, or 0.74 percent per year. When combined with projected population growth of 0.9 percent per year, total demographic trends will increase resource use by 1.6 percent per year. When a cruder measure of utilization is used—total discharges—the annual increase is 0.51 percent per year. Using APS-DRG weights has a meaningful impact on the results, increasing the estimate of aging by 45 percent.

However, aging still accounts for a relatively small portion of the growth in hospital spending projected for the next decade: only 11.8 percent of the

total increase in inpatient spending from 2005 to 2015.

This increasing rate of growth in inpatient utilization because of aging results from the shape of the distribution of inpatient utilization by age. The distribution of charge weights indicates a greater increase in utilization among the elderly than the distribution of discharges; however, both graph lines reveal that utilization begins to accelerate when people reach their mid-50s and continues to rise until death. Consequently, as the baby-boom generation ages and the proportion of the population older than the mid-50s swells, inpatient utilization rates will accelerate accordingly.

Variation by medical condition

The effect of aging varies widely across the types of medical conditions treated in an inpatient setting. Population aging will have a relatively large effect on the use of services by patients classified in the MDC “diseases and disorders of the circulatory system”. This MDC includes such highly used cardiovascular DRGs as 127 (heart failure and shock), 143 (chest pain), and 107 (coronary bypass with cardiac catheterization). Inpatient utilization for this group of DRGs will grow 11.8 percent per person, or 1.12 percent per person per year from 2005 to 2015, as a result of population aging alone. Aging will increase utilization for this MDC for 1994–95, 2004–05, and 2014–15 by 0.65 percent, 0.93 percent, and 1.23 percent, respectively.

Population aging will also have a relatively large impact on a number of other categories of medical conditions, such as diseases and disorders of the male reproductive system (which includes the DRG for prostate cancer), diseases and disorders of the respiratory system (which includes the DRG for chronic obstructive pulmonary disease and pneumonia), and disorders of the musculoskeletal system and connective tissue (which includes a number of orthopedic-related DRGs, including hip replacement). Aging will drive 1.50 percent, 0.97 percent, and 0.84 percent per person annual growth in use for these MDCs, respectively.

Just as aging has a particularly large impact on selected sets of medical conditions, it also has the opposite effect on others. This is particularly true for DRGs related to maternity care and

mental illnesses. In fact, population aging alone would actually lead to virtually no change or to a decline in annual per person use of three heavily used MDC groupings: pregnancy, childbirth, and the puerperium; newborns and other neonates with condition origin in the perinatal period; and mental diseases and disorders. From 2005 to 2015, if nothing other than the age distribution of the population changed, per person use of DRGs that fall under the two maternity care–related MDCs would change by –0.26 percent and –0.03 percent per year, respectively; during the same period, use of the DRGs for mental illness would decline by 0.12 percent per year.

Discussion and Implications

A growing body of research in recent years has begun to quantify the effect of coming changes in the age distribution of the U.S. population that is largely attributable to the aging of the baby-boom generation. Although aging will likely have an important impact on spending, its magnitude will be dwarfed by the impact of advances in technology and other factors that affect medical practice patterns.

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To see this, consider coronary artery bypass graft (CABG) surgery and percutaneous transluminal coronary angioplasty (PTCA). Between 1993 and 2002, if nothing had changed other than the age distribution of the population, use of each of these procedures would have increased 0.6 percent per year. However, the actual rates of growth for these two procedures were strikingly divergent: The number of patients who received PTCA during an inpatient stay grew a total of 83.4 percent, or 7 percent per year, from 1993 to 2002, while the number of patients on which CABG was performed grew a total of 1.4 percent, or 0.2 percent per year.

This study does not take into account potential interactions between changes

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in practice patterns and aging—in other words, will new technologies that increase use of services affect older people disproportionately? The authors did not see compelling evidence of any particular interaction. The empirical record of the past forty years does not exhibit a consistent pattern supporting the notion that the distribution of utilization by age is shifting toward older ages. Between 1963 and 1987, spending on hospital care per elderly American (8 percent per year) did in fact grow twice as fast as such spending on people under age sixty-five (3.8 percent per year).

Between 1987 and 2000, hospital spending among the population under age sixty-five outgrew spending on elderly Americans by a three-to-one margin (3 percent versus 1 percent per year).

However, that pattern reversed itself between 1987 and 2000, when hospital spending among the population under age sixty-five outgrew such spending on elderly Americans by a three-to-one margin (3 percent versus 1 percent per year). Although having a large elderly population could influence priorities in industries that develop new medical technologies, this historical record suggests that advances in technology not responsive to health system developments will probably dwarf this incentive. Some have maintained that those in the baby-boom generation culturally are inclined to make greater demands on the medical care system than their parents and grandparents did, but this has proved difficult to validate as baby boomers have dramatically expanded possibilities to draw from than did those a generation or two older.

The analysis provides some guidance for hospital industry planning for expansion of capacity. In general, the

effect of aging effect on use of inpatient services will be small, but it will have a larger impact on use by patients with certain types of medical conditions that are more concentrated among the elderly. But for many of the conditions highlighted in this analysis, changing technology is a much larger factor in changes in treatment than population aging. In local geographic areas, forecasts of population growth will probably be more important for planning than forecasts of aging will be.

Hospitals must plan for capacity for ancillary services that will serve both inpatients and outpatients. But projecting demand for outpatient services is particularly difficult now because of recently developing trends of investment in outpatient facilities. These facilities' competitive threat to hospitals could not have been foreseen a few years ago, which makes its importance five years into the future very difficult to predict.#

Managing Your Middlecent Workforce

"They make up more than half your workforce. They work longer hours than anyone else in your organisation. From their ranks come most of your top managers. They're your mid-career employees, the solid citizens between the ages of 35 and 55 whom you bank on for their loyalty and commitment. And they're not happy. In fact, they're burned out, bored, and bottlenecked, new research reveals. Only 33% of the 7,700 workers Robert Morison, Tamara Erickson and Ken Dychtwald, surveyed feel energized by their work; 36% say they're in dead-end jobs. One in three is not satisfied with his or her job. One in five is looking for another.

The survey results are discussed in *Managing Middlecence*, published in the Harvard Business Review, March 2006

Welcome to middlecence. Like adolescence, it can be a time of frustration, confusion, and alienation. But it can also be a time of self-discovery, new direction, and fresh beginnings. Today, millions of mid-career men and women are wrestling with middlecence--looking for ways to balance work, family, and leisure while hoping to find new meaning in their jobs. The question is: Will they find it in your organization or elsewhere?

Organisations are ill-prepared to manage middlecence because it is so pervasive, largely invisible, and culturally uncharted. That neglect is bad for business: Many companies risk losing some of their best people or--even worse--ending up with an army of disaffected people who stay. The best way to engage middlecents is to tap

into their hunger for renewal and help them launch into more meaningful roles.

Perhaps managers can't grant a promotion to everyone who merits one in today's flat organizations, but you may be able to offer new training, fresh assignments, mentoring opportunities, even sabbaticals or entirely new career paths within your own company. Millions of mid-career men and women would like nothing better than to convert their restlessness into fresh energy. They just need the occasion--and perhaps a little assistance--to unleash and channel all that potential."

Robert Morison, Tamara Erickson and Ken Dychtwald are the authors of *Workforce Crisis: How to Beat the Coming Shortage of Skills and Talent*.

A noted psychiatrist was a guest at an academic function, and his hostess naturally broached the subject in which the doctor was most at ease. "Would you mind telling me, Doctor," she asked, "how you detect a low intellect in somebody who appears completely normal?"

"Nothing is easier," he replied. "You ask a simple question which anyone should answer with no trouble. If the person hesitates, that puts you on the track."

"What sort of question?"

"Well, you might ask him, 'Captain Cook made three trips around the world and died during one of them. Which one?'"

The hostess thought a moment, and then said with a nervous laugh, "You wouldn't happen to have another example would you? I must confess I don't know much about history."

Leadership Myths: Leaders are born not made

On reflection, I am not sure that Shawn Bishop taught us much about leadership at our March seminar. What she did do, and this is the skill of a facilitator, was to show true leadership and get us to tell each other the immense amount we already knew about leadership. And along the way, led by Shaw's dynamic presentation style, we had a lot of fun, sipped fine wine, scoffed Medirest's savoury nibbles and networked galore.

Shawn completed a Master of Science Degree in Education in The United States. After moving to New Zealand in 1985 she completed her post-graduate work in Personnel Management and Industrial Relations at the University of Auckland. Shawn held senior management positions with large national NZ organisations for many years. She was disappointed when training programmes these companies brought in failed to create lasting results. "When the workshops were over the manuals went onto the bookshelves - and nothing changed." Although with electronic manuals we are a little smarter – while they are even less likely to be read, they do not gather dust.

This was the catalyst for Shawn to create her own leadership development programme, which insisted on practical application after the initial training. Incorporating adult learning concepts, a modular format and participant project work combined with an accountability for the learners to produce results, her leadership programme has filled a much needed niche in the training market. Shawn's topic was "Leaders are born not made – what utter rot. It is a really dangerous myth. She invited us to identify some of the down sides for organisations of the "leaders are born" approach and we came up with these bon mots.

- There is a loss of creativity – people do not think outside the square.
- There is an acceptance of poor performance because, "there is nothing we can do."
- A risk of accepting the loudest and most assertive opinion – "storming".
- Missing golden opportunities –

people at coal face may have better ideas but have no opportunity to contribute.

- There is an awful pressure on those in leader role who "have to do everything" and inevitably burn out.
- A loss of the best talent – those not recognised go to greener pastures.

A cloning of the current style offers no variety or diversity of approach.

On the other hand we identified a number of advantages for organisations when they adopt a leadership development programme.

- It saves time because others do the work
- With more skills there are more succession plan possibilities
- Encourages the retention of staff by offering them role embellishment
- Allows multiple perceptions to come out
- There are more choices to lead projects etc
- Stops people from opting out – not my job

Some bad leaders rule by fear. Most of us can recall at least one example in their working lives. This writer had the opportunity to watch from the side as a former Prime Minister named Robert practiced this to the nth degree. Faced with a bad leader what can one do without taking the ultimate option of moving on?

While the meek may not inherit the earth (at least in our lifetime), Shawn's audience suggested that the best



Shawn Bishop

counter to bad leadership was to "hang on in there" as the survivors will eventually prosper.

In the meantime, bad leaders can galvanise others into a strong team. That is, informal leadership comes from within the group so a lot can be achieved without effective formal leadership.

The ideal of course is to develop the leadership potential within your organisation. Shawn believes that workshops on their own can be waste of time – on her courses people have to go away and work on projects associated with their work. In this applied learning environment, not only are the individuals improving their skills, their organisation also benefits. It is also allows her to monitor how people change during the training and for her, this is one of the most satisfying parts of her job.

For more information visit : www.leadership-unlimited.co.nz #



Interaction in full swing

Visibility is the key for professional success

For those of you who are shy or reticent, and with busy lives we all lead, it is getting more difficult to develop connections with other people. The workplace has many obstacles to those who are shy, to the point that they prefer solitary work than working on projects with others.

For shy or introverted professionals, networking is a survival skill with which they need to cope. Shyness can become a barrier if you let it. However, networking is a skill you can learn.

The following tips can make dealing with your shyness easier, and take you and your business to the next level.

1. Take Small Steps.

Do not expect to master networking overnight. It takes time. Many introverts think they will wake up one day and become a powerhouse networker but this is usually not the case.

Just enter the world of networking one small step at a time. Add something new, such as one question to ask (discussed later in this article), at each subsequent event. Over time, it will become much easier.

2. Set Clear Goals.

Think first about what you want to accomplish in your life and your business. Then consider the alternative: What do you think would happen if you allow your shyness to continue and stop you from pursuing your dreams? Take the time to define your goals and write them down.

3. Prepare and Practice.

A key step to overcoming shyness is preparation and practice. Write down in advance some questions you think will stimulate and sustain a conversation. If you find yourself somewhat nervous when meeting someone new, try practicing what you are going to say with another person or even to yourself in the mirror. Then practice in an environment where you won't feel intimidated. Role-play with someone you feel comfortable with. This way, when you feel unsure of yourself, you will still have an idea of what you want to say and how you are going to say it. You may even want to write out some questions on 3x5 cards and read them before you attend the meeting or event.

4. Feel comfortable with yourself.

At times, you may find your reluctance

to network results from feeling self-conscious. It may also inhibit your communication skills. Prior to attending a networking event, use the above skills and practice, practice, practice. This will actually help to reduce your anxiety and you will not feel as shy.

5. Attend events that have a purpose.

Use your positive skills and try to meet several people. You may find underneath it all, that you are not totally an introvert. You may find that after you are in a situation or at an event, you relax more. As a result, you gain more confidence and feel more secure about yourself. If you feel shy or nervous at these events, maybe you need to start on a smaller scale. Maybe go to your local home and garden show. There at least you can go and ask questions about various things you may need around your house and help develop your networking comfort level.

Before you decide that it is not worth talking to others or in attending a particular event, ask yourself, "What positive thing can I say that can make this encounter worthwhile to me?"

6. Turn your focus away from yourself.

When you are at a networking event, instead of feeling embarrassed about having someone ask things of you, switch the focus of the conversation onto the other person. Ask a question that makes the other person give a response (rather than a yes/no question). Introduce yourself to others. Ask a question to the other person or persons.

Ask questions like:

- What business are you in?
- That is very interesting - tell me about it.
- What do you do there?
- How did you get into your business?
- How is your industry doing (if the other person is in another field)?

For those who do not like to talk a lot with others, listening is just as important as talking when it comes to establishing good relationships with others.

Most of the time, extroverts prefer having someone listen to them talk. Just ask an open-ended question and sit back.

When you allow people to talk about themselves, they will be more likely to enjoy the conversation with you they will view your business in a positive light. To some extent, you are indirectly promoting your business. When they need someone with your products or services, they will remember what a good listener you were. And depending on how comfortable you feel, you may find yourself introducing someone you just met to others.



Members networking at our March seminar

7. Reward Yourself.

Prior to attending a networking event, decide what reward you are going to give yourself for speaking/introducing yourself to at least three to five people and for staying longer than you plan. And be sure you withhold the reward if you do not meet your goal.

The bottom line is that the more you network or meet others, the more confident you will become. In turn, the more confident you feel, the less shyness will be in your way. And the closer your dreams and goals will be to becoming reality.

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NHS Bash a Bureaucrat Season

Bash a bureaucrat season in the NHS is in full swing as both the opposition and the media see the NHS struggling to deliver despite the billions of extra funding it has enjoyed.

We could sit back and think, “that is something happening far away and we need not worry.” That would probably be wishful thinking. Already there are signs that the opposition in this country see health as an easy target for government bashing.

At a time when a leaked Treasury document says that Britain now has the best-paid doctors outside America there is an unmistakable whiff of political panic as the NHS lurches from one crisis to another. On March 7th, Sir Nigel Crisp, its chief executive since November 2000, abruptly announced that he was taking early retirement. There is little doubt that Sir Nigel has paid the penalty for a series of financial reverses and managerial mishaps.

While centrally negotiated contracts for hospital consultants, family doctors and nurses have proved much dearer than expected, they seem to be removed from political and media blame. Managers are a much easier target. Frank Dobson, a former health secretary, has been quoting a sum of £200 million health services are supposed to have spent on consultants. In his time at the Health Department, Mr Dobson imposed a £25,000 limit on any management consultancy contract being signed without his direct approval.

The government's record on the NHS has been patchy. It spent its first term in office destroying the internal market that the Conservatives had established, believing that health care could be improved just by throwing money at the system, which it did enthusiastically. It has allowed the trade unions to take it to the cleaners in pay deals and adopted a top-down policy of command-and-control targets that could have come straight out of a Soviet rule-book.

Yet in 2002 it realised that the money would be wasted without structural reform, and set about introducing a more ambitious internal market than the one it had junked. Primary-care

trusts buy health care from wherever they choose—including an increasing number of private clinics—on behalf of patients. And a new payments system is being introduced to make hospitals more responsive to purchasers' demands.

Even so, despite a funding bonanza that has doubled the NHS budget in the past seven years; many hospitals have gaping holes in their budgets. In the financial year to March 2006 the health service was likely to run a deficit of £800m.

The common approach to overspending is to cut staff. The Daily Telegraph is running a daily tally of health service job losses and publishes a direct e-mail link for health care workers to blow the whistle on further job cuts. The March announced losses reached 4,870.

The Audit Commission said it was preparing a report on the financial problems in the health service. The public spending watchdog said its report, *Learning Lessons from Financial Failure*, due in May, would set out common factors that had led to deficits and recommend how to note the early signs of failure.

In 2005/6 the commission published a record number of “public interests reports”. An unprecedented 24 “naming and shaming” reports were published on hospital and primary care trusts and strategic health authorities. Such reports are published only when the auditors identify failing financial policies which they believe cannot be resolved in the short term.

The inefficient configuration of services is another reason why the red ink is appearing. Hospitals are doing things—such as diagnostics, some elective surgery and minor injuries—that might be done better in other places. And in some areas—in a ring around London, for instance—there are too many mid-dling-sized hospitals offering treatment that could be provided more cheaply and safely at fewer, larger and more specialised hospitals.

What's especially worrying for the government is that these difficulties have arisen before market discipline has really had a chance to bite. That will

happen in earnest from April, with the extension of the new payments system that rewards hospitals according to the volume of treatments that they undertake, rather than through “block contracts” linked mainly to previous budgets. The new system now covers £9 billion of work in hospitals; in the financial year starting next month, it will rise to £22 billion.

Similar systems have saved other countries a great deal of money. In Sweden, for instance, a study on health-care reforms found that the greatest boost to efficiency came from a similar change in the way hospitals are paid. According to the OECD, such per-case payments can save 10% or more compared with previous financing methods.

But there is nothing painless about the predicted gains in productivity: they will be made as hospitals change their ways because they are threatened with losing custom. Many will succeed in treating patients more efficiently. But some will run into difficulties because their managers won't cope as the new payments system reveals that services could be provided more efficiently elsewhere.

The government's response has been to send 18 hurriedly assembled “turn-around” teams into troubled NHS organisations to fix their finances. However, Ministers also need to grit their teeth and accept that, where the new market in health care reveals that hospitals are providing the wrong thing in the wrong place, some will have to close. There will inevitably be fierce local opposition, and the government will need to try to defuse that by providing more free-standing “A&E lite” clinics to provide the emergency services that people reasonably expect to be available nearby when they need help quickly.

If the government starts bailing out failing hospitals, managers will know that they will never seriously be subjected to market disciplines, and the chances of boosting the health service's efficiency will evaporate. #

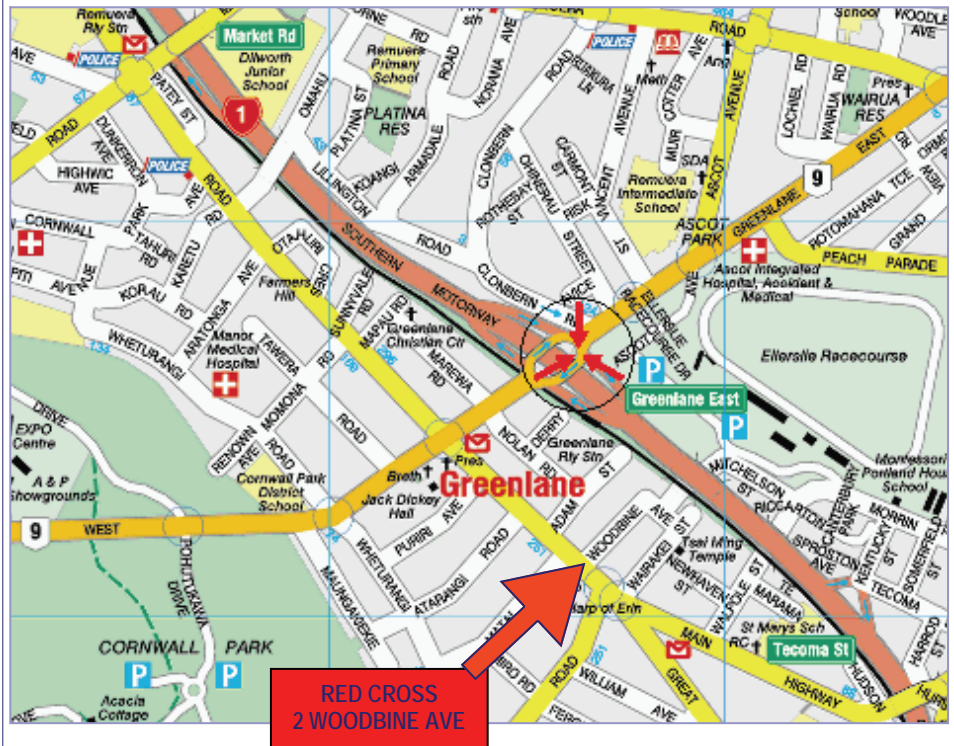


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Inform Editor Bruce Parkes



Seminar Programme

May 17th

@ Red Cross Offices, 2
Woodbine Ave, Green Lane
5:30p.m. for 6p.m.

Taking the Next Step Up Geoff Lorrigan

Non Members Welcome

Cost

Members	Free
Non Members	\$25

Our seminar programme is
supported by:



Continuing our recent theme of Leadership, we are delighted to have Dr Geoff Lorrigan, director of the Institute for Strategic Leadership present our next seminar on May 17th.

Geoff was previously Associate Dean at the University of Auckland, and Director of the University of Otago Advanced Business Programme. He was also the Director of The Auckland MBA and The Otago MBA and held Professor of Strategy appointments at both universities.

As well as running very successful residential leadership courses, Geoff coaches and mentors CEOs, Directors and high potential individuals. He also consults widely to public and private companies in the areas of strategic planning, the development of high performance teams, creating shareholder value and supporting technology start-ups.

Geoff will talk about what makes YOU an effective leader. Requiring self-awareness and the ability to understand and interact with others whilst appreciating differences, it also requires strategic thinking and the capability to develop and work in high performance teams.



Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
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