



Inside this Issue

Managerial effectiveness in the Health Sector: What it means in 2004?	1
Harkness Fellowships available	3
A Canterbury Tale	4
Regulation is the best driver of Patient Safety	5
Profile	6
Upcoming Events	6

Managerial effectiveness in the Health Sector: What it means in 2004

The 30 plus members attending our February seminar were treated to a preview of Rod Perkins' latest 'work in progress'. Rod, Senior Lecturer in Health Management and an Associate of the Centre for Health Services Research and Policy at the University of Auckland, has been looking at what it means to be an effective manager or administrator in a public health organisation.

The working title for Rod's presentation is "Managerial Effectiveness in the Health Sector - What it means in 2004". Rod, in his introduction expanded that to say his presentation was based on the subject of his PhD thesis, called "A study of managerial effectiveness in New Zealand from 1944 to the year 2000. For his study Rod interviewed a range of people who had been in the Health Sector during four periods and asked them to think of both effective and ineffective administrators or managers of that period and what traits made them effective or ineffective at their job. The way effectiveness is construed is what it means - there is no 'holy grail' of effectiveness that we can try to define. The method Rod used is known as a 'repertory grid'

Effectiveness is context dependant - change the context and you change the way people think about effectiveness. It is different in health than in say in railways; different in profit than in non-profit organisations, different in managing nursing than in managing an x-ray department etc. Therefore, to understand effectiveness we need to understand three different elements: the context, then the job and then the person.

Rod's study based on the public sector covered four periods:

1944 - 1967 "The Post Welfare 'State'"

1968 - 1983 "The Welfare State in Crisis"

1984 - 1992 "The Reforming State"

1993 - 2000 "The Night Watchman State"

The latest period, from about 2000 and sometimes called the "Third Way" is not covered in his study.

In the course of his study Rod, using categories developed in Flanagan and Spurge's book *Managerial Effectiveness in the Public Health Sector*, interviewed people working in administration or management in those four periods and drew from them constructs of what it meant to be an effective administrator or manager. He was left with a whole bunch of statements about effectiveness, which for earlier periods was about administrative effectiveness, but transitioned into statements about managerial effectiveness as the role shifted from administration to management.

He has set out to see if there is any change in those categories over time. The result, using Rod's analogy, can be likened to taking a pipette and putting in different layers of coloured sand, is similar to what happens in the nature of work - when you get new requirements -

(Continued on page 2)



(Continued from page 1)

for example in 1993 you have to make a profit, in 96 you have got to keep everyone happy, in 99 you have to make 1 and 1 = 4. Those new requirements go in the top, but there is still the old requirements, which used to be the only part of the job like manage the relationships, live within your budget, no surprises, no scandals, keep everything sweet. On top of these go the new requirements like strategic planning, and business planning.

The trend of this nearly 50 year period is one of going from a administration to management, from a master of great deal to a more strategic role, from an emphasis on equity and fairness to getting the job done, from a comprehensive knowledge in all areas to leading a team, from the dictator to the collaborator. A new age manager has replaced the crude macho manager archetype of earlier times.

During the eighties the relationships between the Boards and the 'Department of Health' changed. Until then the job had been to take instructions, then things changed quite quickly. Until the nineties nurses managed the nurses, doctors managed the doctors and the administrators managed the administrators, and each of those was occupational management. Then that changed, working relationships changed and some of those in managerial roles could not handle those relationship changes at all well. Often those who handled them best came from a nursing or allied health background because they were very used to working with professionals.

The trends were a shift from authoritarian views to a more collegial relationship. The effective manager in 2003 sees subordinates as critical to getting the job done with an emphasis on picking the right person for the job. So people are seen to be effective if they made good choices on whom to bring on to the team. The trend is from an aloof no nonsense man in the early periods to a strong personable man or woman in the Third Way state. Now we value trust, ethics, empathy and loyalty.

What does this have to say about the way healthcare organisations should be structured today? What we have at the level of service delivery is a network and that network is comprised of all the health professionals, all of whom are doing their own thing. The effectiveness of an organisation relates to the way in which the hierarchy of the organisation relates to the network. When you examine the way health managers construe effectiveness, there is no reference to hierarchy. Rod concluded, academically, organisations have always been looked at as hierarchical, the time now seems right to re-examine that belief.



Some of the attentive audience

Attention: We need your contribution!

Run an interesting project recently?
Implemented an innovative change to service delivery?
Researched a topic that others may find useful?

Share your experience and knowledge with your peers across New Zealand and Australia.
See your name in print!

Each quarter, the Health Manager journal is published by the College and encompasses a wide range of developments in health management. We are always on the look-out for authors, and each edition has space reserved for a contribution from New Zealand via NZIHM.

Draft articles can be sent to Stuart Francis (stuart.francis@fgconsult.com) on the National Council who co-ordinates the New Zealand Health Manager contribution.



THE COMMONWEALTH FUND HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY

The Commonwealth Fund is pleased to announce the 2005-06 Harkness Fellowships in Health Care Policy. The Fellowships provide a unique opportunity for mid-career health policy researchers and practitioners from the United Kingdom, Australia, and New Zealand, to spend up to 12 months in the United States conducting a policy-oriented research study, working with leading U.S. health policy experts, and gaining an in-depth knowledge of the U.S. health care system. Under a new partnership between The Commonwealth Fund and The Health Foundation, the program includes two additional U.K. fellowships targeted at health care practitioners and supported by The Health Foundation.

Applicants must demonstrate a strong interest in health policy issues and propose a research study that falls within the scope of The Commonwealth Fund's national program areas. Among the issues the Fund addresses are improving health insurance coverage and access and improving the quality of health care services. Its quality programs focus not only on general issues but also on the needs of specific groups, including underserved populations, young children, and frail elders. Studies that include comparisons between the United States and the applicant's home country are encouraged.

Once selected, the Fund will provide extensive support to successful fellows to help them develop and shape their research proposals to fit the U.S. context. Through its network of contacts, the Fund will help identify and place fellows with a mentor who is an expert in the policy area to be studied. In collaboration with the U.K. Harkness Selection Committee, a home country mentor, who will act as a liaison with the U.S. mentor and supervise any cross-national comparisons that are to be conducted as part of the study, will also be identified after selection.

During their stay in the United States, fellows identify and collect data, resolve methodological issues, conduct site visits or interviews, and meet with experts. All fellows will participate in a rich program of seminars and policy briefings throughout the year.

Building on their fellowship experiences, Harkness Fellows have published their project findings in prestigious peer-reviewed journals including the *British Medical Journal*, *Health Affairs*, the *Lancet*, *Quality and Safety in Health Care*, *New Zealand Medical Journal*, *Medical Journal of Australia*, and the *New England Journal of Medicine*. They have moved into senior positions within academia and government, providing valuable contributions to health policy at home and in the United States.

The deadline for receipt of applications is September 1, 2004. In order to apply, applicants must be citizens of the United Kingdom, Australia, or New Zealand and submit a formal application.

Each fellowship will provide up to \$85,000 (U.S.) in support, which includes round trip airfare to the United States, a monthly living allowance, travel to seminars and policy briefings, project-related travel and other research expenses, tuition for related academic courses, health insurance, and U.S. taxes. In addition, a family supplement is available to fellows accompanied by a spouse and/or children.

To obtain further information about the Fellowship program, including a List of Suggested Projects, please see The Commonwealth Fund's web page at www.cmf.org. Application materials and instructions are available in electronic form on the web page. For further questions regarding the program, eligibility, or the research proposal, contact New Zealand's Harkness Fellowships in Health Care Policy Representative, Dr. Karen Poutasi, Director-General of Health and Chief Executive, New Zealand Ministry of Health, telephone: 04-496-2381, or email: karen_poutasi@moh.govt.nz

A Canterbury Tale

Michael Aitken reports 25 Christchurch branch members enjoyed the hospitality of Eurest at their first meeting of the year at the Botanic Gardens Café

The meeting began with the presentation of Fellowship of the ACHSE to Professor Laurence Malcolm. Laurence spoke briefly outlining four positives in the New Zealand Health system as he saw it: Evidence from recent New Zealand and international studies indicate that New Zealand is ahead of the rest of the world in the following.

- * Developing a successful partnership between managers and clinical directors, a key factor in building a better quality more efficient health system.
- * Developing a quality culture with major improvements in both primary and secondary care driven by clinical leaders and managers within DHBs and primary care/primary health organisations.
- * Building a more integrated primary health care system through PHO which are expected by the end of this year to cover some 90% of the population, with emerging accountability for both quality and financial management of primary care resources.
- * Developing an integrated health system through DHBs especially the integration of primary and secondary care with major implications for promoting continuity of care and reducing demands upon hospital-based services.

For the main topic they were delighted to have Professor Peter Davies present "Hospital trends from NZHIS data, 1988-2001: what implications for the health management task?".

Peter and colleagues have been interrogating the NZHIS data from 1988 to 2001 to look at the changes in hospital care and the effects on access for disadvantaged groups and the outcomes for patients. This was prompted by a first look at the data which showed that from 1988 to 2001 the beds utilized in the 32 hospitals studied dropped from by about 40% while the number of discharges increased by around 75%. In this fascinating presentation he also looked at how these trends had varied with the four different health structures (AHB, CHE, HHS, DHB).

In summary:

- * Supply: marked reduction in bed numbers
- * Care: % day stay up, bed days down, readmissions up
- * Activity: overall levels of access and patient throughput maintained
- * Access: maintained for vulnerable groups
- * Quality: declining post-admission death rates, but higher levels of readmission
- * Regime: notable features of trends seem to be a function of phase rather than regime type

A lively discussion ensued with reminiscences from some of those present who had worked through this time of massive change.

The information confirmed that since 1988 the public hospital sector of the NZ health system has become dramatically more efficient (at least judged as according to the use of inpatient beds as a measure of the application of hospital resources) with no drop off in the quality of outcome for patients or access to care for vulnerable groups - a story that is never told.

Michael says it was delightful to have confirmation that good things have been happening in the NZ health system and that whatever crises we face, progress is being made in crucial areas.

REGULATION IS BEST DRIVER OF PATIENT SAFETY

With the publication in 1999 of the Institute of Medicine's report *To Err Is Human*, medical error became an international problem increasingly difficult for providers to ignore. The report described the alarming prevalence of medical errors and recommended a range of activities to improve patient safety. The report set some ambitious goals for all parties in the health care system, calling for a 50 percent reduction in medical errors over five years. To achieve this goal, the report argued that a multifaceted approach was needed, and its recommendations reflected this view.

Kelly J. Devers, Hoangmai H. Pham, and Gigi Liu set out to identify what is driving improvement to patient safety in 12 communities in the United States today. Their report, **What is Driving Hospitals' Patient-Safety Efforts?**, is printed in *Health Affairs* 23(2) 2004.

They found that although some believe that market forces are becoming more important, a quasi-regulatory organization (the Joint Commission on Accreditation of Healthcare Organizations) has been the primary driver of hospitals' patient-safety initiatives. Professional and market initiatives have also facilitated improvement, but hospitals report that these have had less impact to date.

Three general mechanisms can stimulate hospitals to improve patient safety and quality more broadly: professionalism, regulation, and markets. Professionalism is a system of self-governance, wherein members of a profession set and maintain standards primarily through shared values, norms, and educational activities. Regulation is when the government establishes a set of standards to which all parties must adhere.

U.S. health care regulation has been strongly influenced by professionals, in that the government often allows regulatory requirements to be satisfied by adherence to standards established by professional associations, or public and private organizations governed primarily by professionals. For example, hospitals participating in Medicare are required to undergo regulatory review by the Centres for Medicare and Medicaid Services (CMS).

Alternatively, through its "deeming authority," the CMS allows hospitals to participate if they are accredited by a private body approved by the CMS (such as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO). Private organizations fulfilling this role are sometimes referred to as quasi-regulatory organizations.

Finally, purchasers and consumers can use market mechanisms to stimulate hospitals to improve patient safety by rewarding or punishing them based on their patient-safety performance or progress.

The purpose of the Devers, Pham, and Liu paper is to describe hospitals' systems and free-standing hospitals' patient-safety initiatives; their progress toward implementing them; and the relative roles that professionalism, regulation, and markets play in stimulating progress. The paper addresses three specific questions:

- * What are hospitals' major patient-safety initiatives now, and how far along are hospitals in implementing them?
- * What facilitates and impedes hospitals' progress in patient safety in local markets?
- * What impact have patient-safety efforts had on hospitals, the health care professionals working with them, and patients?

Based on their study of twelve communities, they found that quasi-regulatory forces (such as JCAHO) are having the greatest impact on hospitals' patient-safety efforts. Although professional and market initiatives have also facilitated improvement, hospitals in local markets reported that they have had less impact on hospitals' behaviour to date. Continued public and private effort is required to maintain the momentum for medical error reduction as health care costs continue to rise, and to develop the necessary infrastructure and know-how.

These efforts must use professional, regulatory, and market mechanisms to stimulate change and accountability and to help hospitals and clinicians overcome organizational and technical barriers.



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



Inform Editor Bruce Parkes

Seminar Programme

March 29th

@ Brightside Hospital

5:30p.m. for 6p.m.

Using Outlook for Individual Effectiveness

Jim Huse from Huse Hill
Associates

April 5th

@ School of Population Health,
University of Auckland, Tamaki
Campus

5:30p.m. for 6p.m.

How can the UK's NHS attract and keep Nurses and Allied Health Professionals

Professor John Arnold,
Loughborough University

Non Members Welcome Cost

Members \$20

Non Members \$25

Profile

New member of our 2003 – 04 Branch Committee, Sue Shipperlee's career in health began in the mid 1970s when she commenced nursing training at Auckland Hospital. On graduating she specialised in Emergency Nursing and spent 14 years in the Emergency Department at Auckland Hospital in a variety of roles from Registered Nurse through to Nurse Manager and Business Manager for Emergency Services.

Sue escaped from the hurly burly of Auckland ED during this time for an almost mandatory OE, which included a 5 month overland trip from Kathmandu to London. Returning after two years Sue then moved on to positions in the private sector, first as Business Manager for Presbyterian Support at Kerikeri, and then at Lady Allum Village during their redevelopment.

Sue returned to public health in 1998 to manage plastic surgery and hand surgery for the Counties Manukau DHB, and then in 2003 changed roles to manage an elective services project for the DHB. This project is charged with implementing the government's elective services strategy to support reduced waiting times for access and treatment. The objective is to provide access for those with the highest priority and give clarity to patients and GPs on whether assessment and treatment services can be provided in a limited resource environment where there is a gap between community demand and the level of services available from DHBs.

Sue holds a Diploma in Management (Health) and MBA, both from Auckland University.

For 14 years Sue has been a serving officer with the NZ Army Territorial Force Field Ambulance and Health Company. She currently holds the rank of Major and her varied roles have included Officer Commanding and Principal Nursing Officer.



It's a Dunn deal

For those who have not heard the good news being shouted from the rooftops, Branch Committee Chair Trisha Ross is no more. We welcome the same effervescent, energetic madam chair back from her February marriage in her new coat (has she taken off her wedding dress yet?) as Trisha Dunn. We wish Trisha and Max all happiness in their future.



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 electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz