



Coal Face Collaboration and Partnership

A common theme running through the ACHSE conference was the frequent use of the “New Zealand system” as an example of best practice Australians should look to emulate as they struggled to make sense of their Federal/State/Private mix. What was it that New Zealand was doing well? Dr Jan White, Chief Executive of the Waikato District Health Board delivered a keynote presentation with verve and panache to provide some of the answers to that question.

Perhaps helped by the nature of its community, Waikato has been more successful than some in developing partnership and collaboration with both health service providers and their wider community. Jan has kindly agreed to share the notes which provided the bones of her presentation.

“The words “Partnership”, “Integration” and “Collaboration” have almost become the new buzzwords in the health sector. This is not surprising as around the world we are all looking at ways to make a difference to the health of our populations in the face of rising costs, rising expectations, changing lifestyles, changing population demographics, new technologies and so on. Although there is increasing evidence around the world that partnership is one way of helping us to achieve our objectives, whether or not it leads to better outputs is still probably open to debate. So whether or not this will translate into better outcomes has still to be decided.

There has been a significant amount of research, particularly in the western world about partnership and collaboration in the health sector. Common threads have appeared in all findings. Some of these are:

Partnership and collaboration are usually driven by the recognition that a problem is larger than just one organisation. A range of stakeholders recognise a common problem and recognise that there is interdependence if a solution is to be reached. This process is usually enhanced if one stakeholder who has legitimate authority and strong personal attributes of leadership becomes the convenor.

For stakeholders to work together to develop shared objectives and values there must be a distribution of power between all participants. Mutually acceptable frameworks and structures are necessary to allow implementation of any solution.

It is particularly in the last area that collaboration has fallen down. Reasons for this include legislated structures, antagonistic organisational drivers, and individual defence of power bases and so on. However, there are also good examples of beneficial collaboration that have occurred despite what might seem to be totally discouraging environments. Some of the happenings in New Zealand over the last four years exemplify these comments.

It is now almost five years since District Health Boards (DHBs) were established in New Zealand. Prior to this time the basic structure was that of a Ministry, a purchasing agency and individual providers (hospitals) i.e. one level of government with responsibility for health which, of course, contrasts with Australia. The providers were held accountable for delivery on contracts but had very little connection to the broader strategies of health.

The New Zealand Public Health and Disability Act 2000 changed all this. The purchasing

(Continued on page 2)

Inside this Issue

Coal Face Collaboration and Partnership	1
Remember those old records	4
Newspaper for the Aged Care and Community Care sectors	5
The new holy grail: An ideal health funding model	6
Our sponsor Euresst has a new name	7
Fellowship 2005: A walk into the unknown	7



Dr Jan White

(Continued from page 1)

authority and the separate hospital structure were abolished and replaced by 21 DHBs. The Ministry remained with its prime responsibilities of implementing Government direction and advising Government, developing policy and strategy, funding the sector and monitoring performance.

District Health Boards are the operational arm of Government, with 21 partly elected Boards directly responsible to the Minister of Health. Each Board is responsible for the health status of its catchment population and is mainly bulk-funded on a population basis. Each Board plans and funds services in its area, either through its own provider (hospitals, some community and mental health services), primary care providers (including General Practitioners), other non-government community providers, community laboratories and pharmacies, rest or nursing homes and home care services. The only aspect of the continuum of health-care that has not been devolved to the Boards at this time is Public Health. However, this is a relatively small part of the health budget and focuses on national screening and prevention programmes. Most District Health Boards have also invested heavily in this area.

In summary, District Health Boards have the funding and responsibility for improving the health status of their population with the freedom to move funding between providers and sectors as needed, and to make judgements about prioritisation, particularly the balance of investment in disease prevention and health promotion and disease treatment. This structure has provided a platform for a range of partnerships, some mandated, some expected and some totally informal.

I would like to quickly run through examples of collaboration that are occurring, starting with central government and working down to individual providers and health professionals. Not surprisingly, as you will see, the place that it is really happening is at the coalface with the individual professionals!

The Public Health & Disability Act requires District Health Boards to form “partnerships” with their communities and to foster a sense of community ownership of health services. This has been implemented in a range of fashions across the country. In my organi-

sation it has seen the establishment of seven elected Community Health Forums, serviced by the DHB. These Forums are able to raise local issues and are the key information disseminators of what the District Health Board is planning or doing. Despite a lot of scepticism, the structure has been very beneficial to both parties.

In this day and age it is relatively rare to find a community which is prepared to prioritise what can and cannot be afforded and to champion realistic expectations across the population. Yet that is what has happened!

A good example of this would be the involvement of a local Forum in working with the DHB to agree on how the local hospital and its services should be upgraded. In this day and age it is relatively rare to find a community which is prepared to prioritise what can and cannot be afforded and to champion realistic expectations across the population. Yet that is what has happened! However, responsibility is not all one-way.

If a partnership is to truly be a partnership there needs to be some equality in decision-making. A commitment has been made by the DHB that issues raised by the local Forums will be addressed wherever possible. I report to the Board on all issues raised through this process at open Board meetings and am held accountable for taking appropriate action. Where this is not possible, I am expected to ensure appropriate and open feedback is given to the community.

Central Government has, for the last three to four years, put an emphasis on Government departments and sectors working together to achieve joint objectives. This has been manifest through the development of key societal goals for the country, which all Government departments are measured against. The current goals include three which have a major health focus – healthy eating and activity, drugs and alcohol and family violence. Whilst health may be the leading agency in these goals, it is not alone and a multitude of other Government departments and organisations are expected

to contribute to outcomes. Such a philosophy is clearly spreading through all the operational organisations, as well as those at a policy level.

A “review of the Centre” was undertaken to develop a framework in which the bureaucracy should work to achieve these Government goals. A number of arrangements have been made at the departmental level to improve the culture of collaboration. However, it should be noted that it is recognised the place to actually see some real outputs is at the provider level, not the bureaucratic level.

The Minister of Health each year writes a Letter of Expectations to DHBs. Always included is an expectation that there will be intersectoral and inter-DHB collaboration.

In the Waikato, a framework has been established to facilitate intersectoral relationships. A virtual entity, Intersect Waikato has been established which comprises the regional Chief Executives of all Government departments, the DHB and local Government, with a charter to build the culture of working together and blurring the boundaries between organisations. Initiatives between organisations are many and varied. Intersect itself has championed some broader developments such as the establishment of a one-stop one-shop service for Refugees and New Migrants and is currently working on a broad Youth programme which has some of the features of the Healthy Cities model.

A further example of intersectoral work the DHB is involved in is Project Energise, a large targeted school programme focussed on working with students, families and teachers to improve nutrition, exercise, oral health and a range of other measures such as truancy. The programme is funded by the DHB and is intervening with 1200 students in a range of schools with an equal number of students in a control group. The project is implemented through the Education department and the regional Sport’s Authority. Corporate involvement in areas such as the provision of free milk and fruit has also been put in place. This has not required the establishment of a separate formal structure but has been driven by all parties having a single objective and recognising that nobody can tackle the issues alone.

(Continued on page 3)

(Continued from page 2)

A similar programme is Te Wai O Rona, a diabetes prevention strategy focused on Māori. Over 5,000 Māori are currently in the programme and it is being overseen by a broad stakeholder group comprising health providers, corporate organisations, Māori organisations and academia. Overall, 35 organisations have and are contributing to the programme. Once again, they have been drawn together by a common problem and have agreed a framework to address the issue. Direct funding is being provided by the New Zealand Health Research Council and the DHB.

There are two levels of inter-DHB collaboration. Nationally, the 21 DHBs have established a formal advocacy organisation DHBNZ. This organisation is owned by the 21 DHBs and has a major role of facilitating matters nationally whilst recognising the independence of each DHB. This is a fine tightrope to walk but goodwill, leadership within the sector and the common objective of improving the health of the population have led to rapid progress being made. There is now an agreed structure for decision-making which includes the fact that if 75% of DHBs are in favour of a particular course of action, it is expected all DHBs will support it. This framework also recognises that some decisions may have a short-term negative impact on an individual DHB and explicitly opens the way for other DHBs to provide financial support, if necessary. This was the case during recent national industrial negotiations. Health unions have only recently been able to legislatively move to national agreements, instead of local employer agreements. This has meant the DHBs must negotiate to-

gether and come up with one agreement across the country for the particular group involved. During what is a transitional period, the collaborative culture between DHBs has been strained but has held and is still being strengthened.

“Regional” collaboration between DHBs is also expected. Although there are no mandated regions, there are four geographical groupings of DHBs. A strong sense of partnership and collaboration is fostered and is manifest in a variety of ways. There may be sharing of central resources through a formal Shared Agency, development of standard policies and developmental programmes, joint credentialing of staff, standard approaches to performance monitoring and auditing of external providers, sharing of staff when one DHB has a crisis, regional service planning etc. Once again, at times the issue of autonomy rears its head but, in general, collaboration is good. This is based on the recognition that such collaboration can only improve standards, prevent duplication and maximise the percentage of funding available for direct service provision.

At the local DHB level, a range of partnerships is fostered. This is particularly so with local Government and across all health providers.

Local Government, through District Councils, has a responsibility for the preparation of long term community plans. This has only recently been legislated and means that Councils must build into their plans all the objectives of other organisations, such as the DHB in their area. Whilst this can be time-consuming from the point of view of meetings and consultation, it also has the potential to provide benefits. In Waikato there

are 10 District Councils we work with and the relationship is helping to ensure that we are both moving in the same direction and not duplicating investments.

Perhaps the area with the greatest immediate and visible benefits is that of collaboration and partnership between providers. The obvious partnership is between hospitals and primary care. In some areas in New Zealand, joint planning and support between the groups has led to measurable decreases in hospital admissions and improvement in health status. Another not so obvious benefit has been the building of a different culture.

Observing hospital specialists being involved in meetings with experts across the continuum of care has been an eye opener. It has led to many specialists being better able to appreciate their place in the continuum and the need to be involved in making decisions on where it is best to invest to get the best outcomes.

From what I have said, you may be led to believe that all is rosy in the “Land of the Long White Cloud”. Of course, this is not the case and as with all other countries, there are ongoing problems. However, I think it is fair to say that the current structure has paved the way for a change in culture from the top to the bottom of the sector. As partnership and collaboration become embedded into the structure, benefits will be realised. This might be through formal or informal partnerships but the reality is that if the health professionals accept partnership as the way to move forward, it will happen despite what might be seen as disabling structures and environments. §

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 e-mail the Editor for more information at admin@nzihm.org.nz

Remember those old records

Every health care organisation has truck loads of them. Not phonograph records. Just mountains of paper, or increasingly electronic data. The Health Retention Regulations require **all** healthcare providers to keep records for a minimum of ten years. Then we can dispose of them? Wrong. Entering from left stage is the Public Records Act 2005.

Note this e-mail from Archives New Zealand to a District Health Board.

"District Health Boards are subject to the Public Records Act. This means that all of the records that they create are also subject to the Act, including personal health information such as patient files.

As you have noted, the two key duties that agencies have to meet is that they must create and maintain records and they must not dispose of records without the authorisation of the Chief Archivist.

You have identified the records that are included in our general disposal authorities (human resources and personnel, financial and accounting, general housekeeping). These records are created and maintained by all agencies and their value as archives is very similar. It is intended to authorise disposal (which is the archival term for either destruction or transfer - i.e. the final decision about what happens to the records) for these records by a general authority which can apply to any agency. However, we need to follow the processes of the Act before the Chief Archivist can authorise the disposal of these records, including an opportunity for public comment. We are currently working our way through this and it is likely that these general disposal authorities will be available for use by agencies in August. Until then, you are not able to dispose of any of these types of records.

Eamonn Bolger, our appraisal manager, is the person to contact if you want to discuss the process of obtaining authorisation for disposal of records (eamonn.bolger@archives.govt.nz).

We are working with the Ministry of Health to develop a disposal authority for personal health information (including patient files), which will then be able to be used by all agencies that hold personal health information. This will take some time, as there are several issues to work through, and until this is completed, you are unable to dispose of any of these

types of records.

Archives New Zealand's Recordkeeping Framework, which is available on our website at www.archives.govt.nz/continuum, provides further information about the expectations for the creation and maintenance of full and accurate records. Further advice will be issued, and will also be available on this website."

The new Public Records Act reflects the changes in technology, legislation and recordkeeping practices that have occurred in the past 47 years. It also, says the Archives website, provides a more enabling and less prescriptive style of legislation.

The Act introduces a new recordkeeping framework, and focuses on supporting good government recordkeeping, in addition to the current emphasis on the disposal of records. Good recordkeeping is simply good management practice and is an essential part of efficient government, as it supports day-to-day operations as well as legal and administrative requirements.

Disposal does not always mean destruction. Under the Act it may also mean

- ✓ Further long term storage
- ✓ Transfer to the control of an archivist
- ✓ Selling to another party
- ✓ Declaring the record is no longer a public record

The Act introduces two key duties that all public offices and local authorities must adhere to. They are:

Requirement to create and maintain records

Under the Public Records Act, all public offices and local authorities are required to create and maintain full and accurate records in accordance with normal, prudent business practice. They must also be accessible over time.



Authority of the Chief Archivist required to dispose of public records

The Public Records Act continues the Archives Act requirement to gain the Chief Archivist's authorisation before disposing of public records. Disposal is the archival term for the ultimate fate of public records; usually either by destruction or transfer to the Chief Archivist.

Appraisal and Disposal Issues

The Public Records Act 2005 says:

No person can dispose of, or authorise the disposal of, public records or protected records, unless they have the authority of the Chief Archivist (Section 18)

The public of New Zealand have the opportunity to comment on recommendations for the disposal of these records (Section 20)

The process used to identify which records are important and should be kept, is called appraisal. The process of deciding who should look after the records or what to do with them is called disposal.

What is Appraisal?

Appraisal is the process of evaluating records to determine:

which records needs to be retained as

(Continued on page 5)

(Continued from page 4)

archives because of their ongoing value to the history to the nation

which should be kept for specific periods

which will be destroyed if they are of little value.

Appraisal is also the process of evaluating activities to determine which records need to be captured, and how long the records need to be kept, to meet business needs, the requirements of organisational accountability and community expectations.

What is Disposal?

Disposal is the final decision concerning the fate of records, eg destruction or transfer to archives.

Disposal is also a programme of activities to facilitate the orderly transfer of intermediate and inactive records from current office space into low-cost or archival storage. It includes surveys, scheduling, and records destruction.

Different Types of Disposal

There are several types of disposal:

- * transferring control of the public record to the Chief Archivist
- * transferring control of the pub-



lic record to another public office

- * altering or destroying the public record
- * selling the public record
- * discharging the public record (which means cancelling the status of a public record under certain circumstances) (Section 25 Public Records Act)

Criteria for Assessment

The authorisation of the disposal of public records must be in accordance with the purposes of the Public Records Act 2005.

The broad criteria are:

Accountability - does the record hold a government organisation accountable for its decisions and actions?

Evidential value - does the record provide evidence of the origins, structure, functions and activities of

Government, and of private and public rights?

Legal requirements - are there any legal requirements for the record to be retained for a set period or indefinitely?

Historical or general informational value - is the record relevant to the historical and cultural heritage of New Zealand, or New Zealanders' sense of their national identity?

Other considerations - this may include the physical characteristics of the record including completeness, physical condition, cost of retention, scarcity, or monetary value.

Audits

Independent audits of agencies record-keeping practices will commence in 2010 and take place every 5-10 years §

Newspaper for the Aged and Community Care Sectors

INsite newspaper is Australia's only bi-monthly newspaper serving the aged care industry and community care sector. While the editorial focus is on Australia, much of the content is relevant and of interest to those in New Zealand working in this sector.

A tabloid-sized publication published in full colour, *INsite* delivers the latest aged care news and views in an easy-to-read format.

With an audited national circulation of 9,981, *INsite's* independent and informative editorial serves as the voice of Australia's rapidly expanding aged care industry. Editorial integrity and industry relevance are assured through *INsite's* editorial advisory group, comprised of key industry leaders. Regular sections include Nutrition, Education & Training, Management, Finance, and Building and Refurbishment.

INsite's readers include chief executive officers, company directors, directors of nursing, senior management, people from Commonwealth & State Government agencies, association board members, proprietors and professionals from related industries.

INsite is available on subscription for \$90 a year or \$240 for three years

All past issues of *INsite* are available electronically as PDF files. To view and download a copy of a past issue, go to www.dpspublishing.com.au/ Without broadband, downloading an issue of *INsite* may take several minutes as the average file size of an issue is 1.5 MB.



The New Holy Grail: an ideal health funding model

ACROSS the developed world, health-care spending is rising and will inevitably continue to increase. As each country feels the financial strain, it is tempting to imagine that there must be a better way of funding medical care elsewhere.

In Australia, for example, calls to have all public healthcare funded from the Federal budget, rather than the current Federal/State split, is being vigorously debated. In Britain, Bernard Ribeiro, the new president of the Royal College of Surgeons, has, in an interview in the Telegraph, called for the National Health Service (NHS) to be financed from social-insurance contributions, as in Germany and France, rather than from general taxation. He worries that a tax-financed system will not deliver enough resources to meet the demand for health-care spending in the longer run.

But there is no ideal system for paying for health care. The European social-insurance model is in even more trouble than Britain's tax-based model. By loading the burden on to employers and workers and thus raising labour costs, it has contributed to the inflexibility of labour markets. In France, the government has resorted to general taxation to spread the burden. In Germany and elsewhere the model looks increasingly unsustainable, not least because its narrow fiscal base will be exposed to unfavourable demographics when the post-war baby-boomers start leaving the labour force in droves.

Nor does America offer an ideal solution. It has a mixed financing system, in which the government stumps up for the elderly and the poor, and employers pay for private coverage of their workers. Health-care spending has reached a record 15% of GDP, dwarfing Britain's 8%, yet 45m Americans lack insurance cover. The rising cost of publicly-financed medical care threatens America's fiscal health.

Neither does the Canadian funding model, often offered as a panacea for New Zealand's funding problems, have the answer. In a keynote address to the ACHSE Congress, Iris Evans, Minis-

ter of Health and Wellness in oil rich Alberta, spoke of their struggle to provide adequate healthcare across the Province within their budget.

No financing model has a clear advantage in keeping a lid on health spending. Despite their apparent variety, they are all forms of insurance, which means that a third party picks up the tab, weakening the resistance to medical bills. These keep on rising because of expensive advances in medical technology in a marketplace where the clinical providers are particularly powerful since they determine what medical care is necessary.

There is no ideal system for paying for health care.

- ✓ The European social-insurance model is in even more trouble than Britain's tax-based model.
- ✓ The rising cost of publicly-financed medical care threatens America's fiscal health

In most insurance markets, competition between insurers puts pressure on the costs of providers. But competition between health insurers is ineffective because the commercial incentives are for insurers to compete for healthy patients, who cost little, and to exclude the sick, who cost a great deal.

This is an argument for a single insurer that can cover everyone and stand up to powerful medical providers. On the other hand, where insurance is through a tax funded State system, political pressures may limit the ability of governments to stand up to the demand for pay increases.

It is the job of governments to try to get more health care for the money that people pay. It is the job of doctors' leaders to get more money for the health care they provide.

In a recent editorial, *The Economist*, advocated that, "rather than focusing on how the money is raised, reformers should worry about how it is spent. Health-care expenditure is rocketing not just because demand is rising but also because health-care markets work badly. They are dominated by powerful providers—companies, hospitals and influential doctors who find it fairly easy to pass on ever-rising costs from new medical technologies to the state or the insurers who pick up most of the tab.

Private individuals' payments generally account for a smallish share of health-care spending precisely because medical bills tend to be so high that everybody needs insurance cover of one sort or another. Taxes, social-insurance contributions and payments by employers all boil down to forms of health insurance.

The cure is not to try to raise yet more money in a different way. Instead, the overriding goal must be to spend the money pouring into health care more effectively by getting wasteful medical systems to work better."

The *Economist* applauds the British governments move to improve the NHS through striving to intensify competitive pressures. One assumes that NHS planners looked and learnt from the New Zealand competitive model of the 90s.

Already they have found that the 300 or so local primary-care trusts that commission care for their populations are not up to the job. So the government is seeking to pep them up. Many will merge and seek greater focus on purchasing by shedding, where possible, their other function of providing some primary care themselves.

Perhaps its time for those NHS policy makers to come back and look at our collaboration and partnership model, described by Jan White elsewhere in this issue. §

Our sponsor, Eurest, has a new name

Medirest has appeared as a new name in the New Zealand healthcare market and with it we have a change in the name of our major national and branch sponsor.

The Compass Group has been a national sponsor to NZIHM for over 3 years through its catering services company, Eurest. At both a branch and national level we have welcomed and benefited from that association. Our association will continue under a new name.

Ross Cameron, General Manager of Medirest, comments on that change.

“Eurest New Zealand Limited has recently changed its name to Compass Group New Zealand Limited to align ourselves with its global parent company, Compass Group PLC. Compass Group NZ Ltd will be the new name of our New Zealand operations with Euresst, Medirest and Restaurant Associates becoming the new business sector trading names, allowing the world’s best practices to be provided under the specialist brands.”

“For the healthcare market in New



Zealand, incorporating public and private hospitals and aged care facilities, we will trade as *MEDIREST*,” said Mr Cameron

Medirest currently provides food and support services (such as cleaning) to over 2,000 hospitals throughout the UK, Europe and Asia Pacific and 50 healthcare sites throughout New Zealand.

Medirest is structured to deliver all non-clinical support services. The company has recruited healthcare specialists from a wide range of disciplines. In addition, our Healthcare Leadership Team has identified the best-in-class healthcare technical solutions from throughout Compass Group’s global healthcare network, and, coupled these with the technology lead management

systems developed for the New Zealand market. The integrated patient food service program, *Catering to You*, is an excellent example of this.

Compass will always have a strong focus on food, and is highly conscious of the food service influence in increasing overall patient and resident satisfaction. However, with the introduction of Medirest this will allow us to compete in the multi-service market where our clients wish to bundle a number of services with the one specialist provider.

Medirest also retains its retail heritage, with 20 staff and visitor cafes in New Zealand hospitals; we understand the importance of providing a space to unwind for staff and visitors. We will continue to operate our own branded cafes with the highly successful *Caffe Ritazza* leading the way.”

For further information on the change Ross can be contacted at 03 348 0095 or rossc@compass-group.co.nz

Fellowship 2005 – A walk into the unknown.

With only our President Trisha Dunn achieving Fellowship of the Australian College of Health Service Executives since our amalgamation, the process is a bit of a mystery to our members. Perhaps that is why so few have applied to join the Fellowship programme. Sparked by curiosity and a little arm twisting from Trisha I set off on my own Fellowship journey.

For me, the objective was not increased status or another line for my CV. I was looking for a benchmark of how I measured up against other health service managers in New Zealand and Australia; and by proxy those in other developed countries. For others, Fellowship may serve as a pre requirement or desirable accomplishment when seeking a new position.

Being accepted into the programme was the first notch on my belt. Acceptance is based on points scored over a number of criteria that allow for the different academic, work and college activity individual candidates present with their application.

The Fellowship programme culminates in a final oral examination (viva), but the process is more about the



(Continued on page 8)



New Zealand Institute
of Health Management
A Branch of the Australian
College of Health Service
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(Continued from page 7)

journey than reaching the final station. Candidates are expected to have worked through a number of management texts and have a good understanding of current issues in the health sector, both in their own environment or jurisdiction and internationally.

Sounds daunting but help is at hand. All ACHSE branches set up led study groups so candidates can share some of the reading load and summarise the results for all. The groups are also able to work through model questions and share the answers they develop.

Being a study group of one I missed that collegial support but gained by being able to adjust the programme to fit in with travel and work commitments. I also enjoyed the undivided attention of Pauline Barnett, NZIHM's Co-ordinator of Fellowship Training. Pauline freely gave me more time than any of my University lecturers ever did and through regular teleconferences she ensured I worked through the syllabus and was ready to face my examination.

Fellowship examinations are usually held in conjunction with NZIHM and ACHSE annual conferences. With no NZIHM conference this year I elected to present alongside the Australian candidates. I was not disadvantaged by facing a mixed Australian – New Zealand examination panel and gained the added reassurance that I had jumped through the same hoops as the Australians.

With fellowship behind me, I have achieved my objective. I do meet the benchmark. Was it worth it? I think so. Sure there was a little extra work, which just meant that I took my day job home a little less often. My understanding of management theory and tools has been refreshed and awareness of health issues widened.

Do I recommend the Fellowship programme? I certainly do. It is an excellent programme with a ridiculously low fee of ACHSE membership plus \$80 at examination time. Now is the time to apply for the 2006 programme. As the Nike ad puts it, **“Just Do It.”**

Seminar Programme

August 30th

@ Spectrum Care, 270 Neilson Street, Onehunga

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

Hospital Management in a Third World Country

By Joyce Hood

Non Members Welcome

Cost

Members Free

Non Members \$25

Our seminar programme is supported by



Make a Spring Resolution to attend our next seminar. Besides the opportunity to nibble and network you will enjoy an excellent presentation

Running a hospital in a third world country requires innovation, improvisation and an exercise of a full range of management skills.

Our August seminar presenter Joyce Hood trained as a nurse in England before coming to NZ in 1965. Since then she has mainly worked in emergency departments and acute areas. She was involved in opening the first private accident clinic in NZ in Auckland in 1988 and has been practice manager of another private accident clinic in Auckland. For the past six years Joyce has worked with the NZ Red Cross as an overseas delegate with missions in Afghanistan, Sudan, Kenya and East Timor. She has worked as a ward nurse, emergency nurse, health delegate, flight nurse and a project manager. In between missions she works as a practice nurse in Auckland.

Spectrum is easy to find with lots of free parking

