



Measuring Provider Efficiency,

A decade of escalating health care costs coupled with a growing focus on the deficiencies in the safety and quality of patient care has created considerable momentum around the concept of measuring both provider clinical quality and provider cost efficiency (cost efficiency from the payer's perspective). The science of measuring physician and hospital quality has advanced considerably in recent years. Organizations like the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) in the USA have developed standard measures that are now widely used throughout health care. Many of those measures have been reviewed through the National Quality Forum's consensus-based process and adopted by health plans and rating agencies. As a result, there is good understanding within the industry on how to measure health care quality at various levels (in particular health plan and hospital levels), even if, regrettably, there is not complete uniformity in the application of those measures, or universal achievement of high performance on these measures.

The same cannot be said of efforts to measure efficiency. There has been a lack of a systematic, empirically informed and consensus-based process to understand how best to measure cost efficiency. Instead, each individual stakeholder has tended to approach this effort separately, which has decreased the industry's ability to learn from natural experiments, understand and catalog best practices, and collaborate on relevant research. Organizations that have introduced efficiency measurement initiatives have often been met with resistance from doctors and hospitals on (a) the meaningfulness and validity of the results, and (b) the lack of transparency in the underlying measurement methodologies. However, the need for valid, reliable, and actionable information on provider efficiency remains very high. Funders and increasingly consumers have a keen interest in identifying doctors and hospitals that consistently deliver good clinical outcomes without wasting resources, and using that information to support benefit designs, network management and public report cards that, together or separately, might induce patients to choose more efficient providers.

A collaborative multi-stakeholder study sponsored by The Leapfrog Group and Bridges To Excellence set out to address this issue. A white paper on the study is available at www.cmwf.org/publications/publications_show.htm?doc_id=257206. The work contained in this White Paper reflects the efforts from health plans, employers, consultants, and providers to define a set of recommendations—Best Practices—that have the potential to improve the measurement of provider efficiency and the science behind it. While the paper focuses on efficiency, all the contributors acknowledge that measuring efficiency should be done in conjunction with measuring effectiveness of care, so that consumers, purchasers and payers can better understand and identify the value of the services being delivered, and providers can better understand the steps they need to take to improve the value of services offered.

The goal is to launch an ongoing process that will provide guidance to all stakeholders based on available knowledge about efficiency measurement. The guidance is provided in the form of principles and recommendations that are believed to be acceptable to—if not necessarily embraced wholesale by—multiple stakeholders. These recommendations are not intended to represent the "last word" on provider efficiency, as both the art and science of efficiency measurement are still in their infancy and are expected to grow. Rather, they are intended to create a framework that is sound enough to use as a basis for measurement today, and to act

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Bridges to Excellence and the Leapfrog group sponsored the study

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as a catalyst for stimulating the evolution of measurement as our knowledge and understanding of this field grows. To that end, an online learning community has been established at www.regence.com/research to facilitate the continued sharing of knowledge.

Furthermore, during the next few years, the NCQA, a key collaborator in this effort, will develop evaluation methods that will help determine the extent to which health care organizations measure physician and hospital performance following principles set forth in this paper. NCQA is currently working with many experts and stakeholder representatives in order to publish a first set of evaluation methods (standards) by July 2005

NCQA's efforts in this area, referred to as the Quality Plus Initiative, are part of its overall work to refine its evaluation methods to focus on critical areas where health care organizations (managed care organizations and preferred provider organizations) can be expected to significantly add value for their members. For a more detailed discussion of NCQA's methods and implementation timetable see www.ncqa.org/Programs/Qualityplus. Until the NCQA's work is complete, the White Paper will be periodically updated to reflect new knowledge and understanding from real world applications in this field through the continued work of many organizations.

The study team's underlying belief is that for hospital or physician efficiency measurements to be widely accepted in the market, they should be feasible to implement for health plans, credible and reliable for consumers, and fair, equitable and actionable for providers. That requires certain conditions to be met.

First, it is important to incorporate enough recent data to develop a statistically reliable determination of provider efficiency. If some data elements are unavailable, they should be omitted uniformly to ensure the comparability of diverse data sources. However, some empirical evidence suggests that pharmacy data is important for measuring

physician efficiency. Reports should only be issued for physicians or hospitals with substantial reportable cases; suggestions are offered regarding reporting thresholds and evidence supporting the recommendation.

Second, they recommend analyzing the data using industry standard episode grouping methodologies, and applying robust case mix and severity of illness adjustments. Even with standard episode groupings and risk adjustment, it is still important to restrict comparison groups to truly comparable facilities or physicians. To that end, they are publishing a separate study that analyzes potential adjustment factors that should be applied to certain types of hospitals when comparing them to non-pure peers using a price-sensitive efficiency index.

Third, they recommend attributing episodes only to providers who have a substantial impact on the episode of care. They suggest a threshold of at least 25% of total professional costs, and believe that it would be acceptable to attribute cases to multiple providers if they each had a substantial impact on the episode of care. They offer some evidence in support of that threshold and methodology.

Finally, they recommend that provider performance reporting should distinguish between differences in utilization and cost per unit. All performance should be reported in valid statistical groupings to reflect the relative performance of the provider, avoiding strict numerical rankings where the risk of misclassification is high. Generally, reporting performance on efficiency should be linked to reporting performance on quality to better understand, measure and communicate the value that is delivered by physicians and hospitals.

Not all organizations will, or can, apply all the recommendations listed in the paper. The authors also recognize that the science, experimentation and research on measuring efficiency should continue in earnest in an open learning community. To that end, they recommend that any organization measuring provider efficiency (1) clearly communicate to all stakeholders (in particular providers and purchasers) the specific methodology used in arriving at the results and any rationale for varying from the recommendations in this paper, (2) publish the confidence interval around the results, and (3) participate in an on-line learning forum at www.regence.com/research to share the results of their work and advance the science in this field.

They also greatly encourage the developers of models and methodologies that measure provider efficiency to make their models available to researchers at very low or no cost, and to develop "freeware" versions of their products that can be used by providers and others to help improve their performance. ■

A man walked in the Lingerie department of Smith & Caughey and said to the sales lady, "I would like a Jewish bra for my wife, size 34B." With a quizzical look the sales person asked, "What kind of bra??"

He repeated, "A Jewish bra - she said to tell you that she wanted a Jewish bra and that you would know what she wanted." "Ah, now I remember," the sales lady replied. "We don't get as many requests for them as we used to. Mostly our customers want the Catholic bra, or the Salvation Army bra, or the Presbyterian type." Confused, and a bit flustered, the man asked, "So, what are the differences?"

The lady behind the counter responded, "It's really quite simple. The Catholic type supports the masses, the Salvation Army lifts the fallen, and the Presbyterian type keeps them staunch and upright." He mused on that information for a minute, then asked, "So what is the Jewish type for?" "They," she replied, 'make mountains out of molehills."

Is Economic Evaluation In Touch With Society's Health Values

Joanna Coast, senior lecturer in health economics in the Department of Social Medicine at the University of Bristol, believes that while health funding is increasingly based on the results of economic evaluation, current methods fail to consider all society's health objectives and are too complex for policy makers to use. Coast discusses the issue in a paper published in the *BMJ* 2004;329:1233-1236 (20 November).

The technical expertise required for conducting economic evaluations and interpreting their results continues to increase. Current best practice includes cost effectiveness acceptability curves, net-benefit frameworks, and probabilistic modelling. These methods are valuable, but by generating a pseudoscientific aura around economic evaluation, they camouflage critical weaknesses in current techniques. In her article Coast describes the evolution of economic evaluation in health care, explores the assumptions underlying current approaches and the resulting concerns, and suggests cost-consequence analysis as a preferred approach to commonly used Quality of Life Year analysis.

Non economists often find it difficult to understand the importance of the theory behind the comparison of costs and effects. The need for theory arises, however, because interpersonal rather than intrapersonal comparisons are involved; the question is not, generally, whether I choose A or B but whether I get A or you get B.

Economic evaluation stems from Paretian welfare economics. It incorporates the principles that individuals are the best judges of their own wellbeing and that, if one person can be made better off without another being made worse off, there is global improvement in welfare. This value judgment is uncontroversial but, in policy terms, practically useless: few policies benefit some individuals without affecting others.

Cost-benefit analysis translates welfare economics into something that can inform decision making. The compensation principle is used to make interpersonal comparisons. This states that global improvement will occur if individuals gaining from change could potentially compensate those who lose and still be better off. So, if my "welfare" increases more than yours from receiving X, I could potentially compensate you and still be better off; global welfare increases if I get X and you do not. An important caveat is that compensation is not actually paid: the aim is to generate global welfare improvements and distribution is irrelevant.

Cost-benefit analysis uses individuals' willingness to pay to assess the benefit of an intervention. So, for example, if group A is willing to pay more for programme X than group B requires in compensation for the loss of programme Y, there is global welfare improvement from allocating resources to X (benefiting A) rather than Y (benefiting B). Funding programme X maximises benefit to society and is thus more efficient.

There are two difficulties with cost-benefit analysis in health care. First, the use of willingness to pay to measure welfare implicitly incorporates income into decision mak-

Terminology used in economic evaluation

Cost benefit analysis—Costs valued in money and compared with outcomes also valued in money

Cost effectiveness analysis—Costs valued in money and compared with a single primary outcome

Cost utility analysis—A specific form of cost effectiveness analysis in which outcomes are measured in terms of QALYs gained

QALY—Quality adjusted life year. A measure that combines length of life and quality of life (valued on an index where 1 represents perfect health and 0 represents death) into a single outcome

ing. This may skew allocation of healthcare resources towards the wealthy. Second, many people are uncomfortable with valuing length and quality of life in monetary terms and thus unwilling to participate in such exercises. These difficulties have led to the development of alternative techniques of economic evaluation and, indeed, changes in underlying theory.

Alternatives to welfare economics move away from reliance on individual welfare and instead aim to pursue societal objectives. They are referred to as non-welfarist approaches or, more specifically, decision maker approaches and extra-welfarism. These approaches all subscribe to the same healthcare objective of maximising health output from available resources but differ in the stated theoretical bases for this objective. The decision maker approach focuses on societal objectives as given by decision makers but, given dissent about whether this moral theory provides sufficient basis for relying on health alone as an outcome for economic evaluation, the non-welfarist approaches largely rely on achieving societal healthcare objectives.

Cost effectiveness analysis results from this theoretical perspective, with the quality adjusted life year (QALY) as the chosen outcome. Over the past 10 years, the QALY has become increasingly accepted and used despite the continued existence of theoretical and methodological problems noted during its development.

The non-welfarist approach has enabled economic evaluation to move forward despite the perceived constraints of welfare economics. Three fundamental assumptions of this approach are, however, overlooked: congruence between the objectives of decision makers and those enshrined in economic evaluation; the validity of funneling multiple outcomes into one simplistic outcome such as the QALY; and the meaningfulness of these complex techniques to decision makers.

Non-welfarist approaches to economic evaluation assume that a decision maker acts on behalf of society and that the objective of the healthcare system is thus to maximise health output (as valued by society) from available resources.

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Even aside from doubts over the existence of this mythical decision maker with a clear set of objectives, the desire to maximise health seems to be largely the objective of economists rather than society. There are three reasons for this view. First, empirical evidence shows that the single objective of maximising health output would not be the basis on which society would wish to allocate its healthcare resources. Second, approaches to rationing based entirely on the cost-utility approach have failed to convince decision makers in practice. This suggests that maximising health output is not an exclusive objective for decision makers. Third, work on the values on which the NHS is based shows that health is only one of many values and that maximisation of health (as opposed to achieving some form of equity in health) is only a subcategory.

Perhaps the major problem facing health economists is the difficulty in ascribing technical answers to what are really ethical questions. Even if society were in touch with its health values, individuals in that society would change their values immediately they became a patient. Who are the decision makers in health? There are at least four interested parties – health professionals, patients, society and payers. Medical practice is fundamentally deontological with health professionals committed to doing the best for each individual patient. The value of this interaction may be oblivious to those intent on the wider utilitarian need to use system resources efficiently.

Thus, ascribing the objective of maximising health to decision makers is no more than a convenience. Any genuine decision maker approach would involve aspects related to equity, need, access, and so on. Economic evaluation based on the non-welfarist approach thus falls into a theoretical void: it is not based on welfare economic theory, nor does it represent all of the decision maker's objectives.

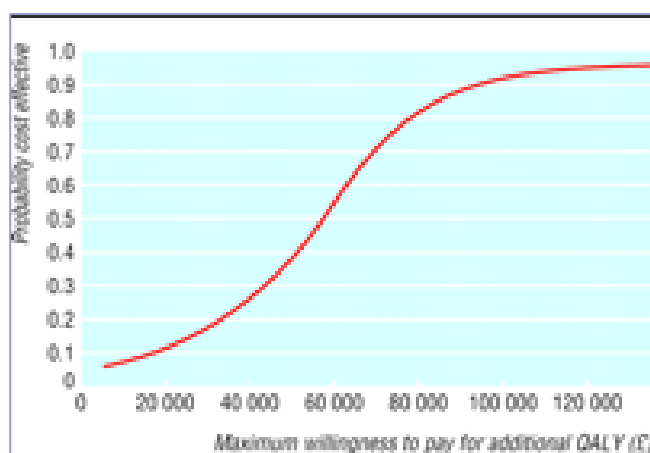
Even if maximising health output is the appropriate objective for the health system, increasing emphasis on cost-utility analysis results in a conflation of "health" with QALYs gained by the patient. This "funneling" of various health outcomes into one, simplistic, single measure, is a further camouflaged assumption receiving less attention than it should.

Indeed, cost effectiveness analysis is increasingly aligned with the biostatistical desire for a single primary outcome in design efficient trials. For many interventions, the focus on a single outcome, even with extensive complex statistical analysis of the uncertainty around the estimates obtained, misses the point. For organisational and other complex interventions, in particular, several health outcomes will be important, not just QALYs. For example, a systematic review of interventions to improve access to health and social care after discharge from hospital found patient outcomes related to mortality, function and disability, quality of life, social support, self esteem, cognitive ability, and satisfaction with services. Furthermore, there are often health outcomes for others, including informal caregivers and parents, as well as important external effects—for example, development of antimicrobial resistance. Use of a single outcome for cost effectiveness analysis fails to recognise that decision making involves making judgments about a variety of important effects rather than just one.

The third questionable assumption is that the complex

technical presentation of results from economic evaluation is meaningful to the decision makers for whom it is intended. Studies have shown that decision makers find the concepts behind QALYs difficult to understand and that knowledge about formal methodology is limited. When many decision makers do not fully understand the basis for QALYs, expecting them to identify their maximum willingness to pay for additional QALYs on behalf of society seems nonsensical.

An alternative is to restrict all economic evaluations to the approach of cost-consequences. Different options are contrasted clearly and explicitly in tabular form for all the relevant costs (resource use). This approach allows decision makers (on behalf of society) to impute their own values to these costs and consequences, which could differ according to local context. Decision makers can see clearly what is included and what is omitted, where information is quantitative and where qualitative. Information about implications for equity, need, and other relevant objectives can be presented as well as information about the health effect on others such as informal caregivers.



To illustrate the outputs from, and uses of, the two approaches let's examine a hypothetical analysis for a comparison of hospital at home and hospital care. The outcome is based on QALYs formed from a five dimension quality of life scale. The cost of treating the patient in the hospital at home was £1200 more than in hospital and made little difference to the mean number of QALYs gained (0.02), where QALYs combine information about mortality and quality of life. This results in an incremental cost per QALY gained for hospital at home of £60,000. Using the cost effectiveness acceptability curve, decision makers would estimate their maximum willingness to pay for a QALY. If, for example, this was £30,000, the probability that hospital at home is more cost effective is slightly less than 20%, but if their willingness to pay for an additional QALY was as high as £80,000, the probability that hospital at home is the more cost effective option would be more than 80%.

A cost-consequences approach would more closely meet the needs of decision makers than current practice and avoid extensive use of inadequate assumptions. Such an approach may not earn researchers the same kudos for methodological research or technical capability as current methods, but it is closer to both Paretian welfare economics and a true decision making approach. It has the additional benefit of being easily understood and thus more likely to influence decision making in practice. ■

Tennessee's health-care experiment overdoses on prescription costs

Despite the continual bad press it receives, the policy in this country of controlling drug expenditure through Pharmac seems to have worked out far better than more liberal policies adopted by or forced on other jurisdictions. The State of Tennessee offers a salutary case study. In 1994, the State faced a \$250m deficit in its administration of Medicaid, the federal-state health-care programme for the poor. In what seemed like a good idea at the time several managed-care organisations were given the job of administering the programme more efficiently. Now, eleven years later, TennCare has turned into the monster that might eat Nashville. In 2004 it chewed up nearly one-third of the state's total budget.

For a programme in such dire straits, TennCare started out well. A 2001 report by the state treasury noted that TennCare spent less per Medicaid enrollee than any other state. But that was when the economy was strong. Moreover, participating doctors found it hard to get reimbursed. In 1999 one of the managed-care firms involved went bust and when the largest, Blue Cross Blue Shield, threatened to leave the programme, the state agreed to take on all risk associated with TennCare.

Most of TennCare's financial problems, however, stemmed from rising costs and over-generosity. TennCare pays for nearly every drug prescribed. It imposes no limits on days in hospital or the number of prescriptions allowed each month. Unsurprisingly, each TennCare enrollee gets, on average, 30 prescriptions per year. Yet Tennesseans are an unhealthy lot. The 2004 annual survey by United Health Foundation, a health-care consortium, ranked Tennessee 48th out of the 50 states. Obesity has doubled since 1990. State governor Phil Bredesen pins much of the blame on a series of consent decrees imposed on TennCare as a result of lawsuits filed by the Tennessee Justice Centre (TJC), a legal-aid organisation. The TJC went to court to stop Don Sundquist, Mr Bredesen's predecessor, paring 200,000 people from TennCare's rolls in 2002. It also kept alive a 1979 lawsuit that required TennCare to pay for 14 days'-worth of any prescription drug it had not yet approved. Mr Bredesen announced his disenrolment plan only after breaking off talks with the TJC, and will have to go back to court this spring to tailor his cuts to the consent decrees.

Mr Bredesen had an idea, he says, to fight rising prescription-drug costs, the bulk of TennCare's spending, by dividing drugs into three lists: the automatically approved, the occasionally approved and the rarely used. The TJC refused to give its blessing.

A study by the Centre for Budget and Policy Priorities, a think-tank, estimates that, thanks to the TennCare cuts, the state will lose \$1.7 billion and nearly 15,000 jobs by 2007. Several hospitals are rumoured to be on the brink of bankruptcy.

Tennessee's difficulties are far from unique. George Pataki, New York's governor, has just announced a plan to cap the state's soaring Medicaid payouts, and Jeb Bush, the governor of Florida, is attempting to shift the costs to private insurers. TennCare may be a model again—albeit an unwelcome one. ■

Targeted Treatments and the Prospects for Pharmaceuticals

Fundamental changes are occurring in the way the pharmaceutical industry discovers and develops according to a new survey of 86 executives conducted by the Economist Intelligence Unit. A white paper on the study is available at www.economist.com

Advances in genetic science have created the possibility of “targeted treatments” that address specific patient populations based upon their genetic profile. Grouped under the heading of pharmacogenics, the intersection of pharmacology, biology and information technology offers the potential for targeting precisely the molecular basis of disease, with fewer side effects resulting from the process.

Pharmacogenics is a response to the fact that that many drugs developed for the mass market do not work for a significant number of patients. For example, the report claims that anti depressants have no effect on 20 – 50% of all users. A major reason for this is disparity is the difference in genetic make-up that causes people to produce slight variations of certain proteins of enzymes that are affected by a given drug.

So what is a targeted treatment? They originated with cancer research and are now branching out to help cure other diseases. In the case of cancer, a targeted treatment hits the abnormal cell while preserving the surrounding normal cells. Hitting the right “target” requires detailed knowledge of the molecular basis of the disease – often called the disease pathway.

Currently, the only commercially available targeted treatment is Herceptin, which was approved in 1998. Herceptin comes paired with a diagnostic test that finds out if patients over express HER-2, based on their genes. If the patient does not have that characteristic they are guided to other treatments. The pay off is two fold. Those who qualify for Herceptin get clinical relief, whereas those who don't qualify are not wasting precious time on a treatment that will not help them.

However, the white paper's authors believe a business case for targeted treatments remains a work in progress. In addition to improvements in applied science for developing products, targeted treatments require pharmaceutical companies to re-think the way they bring a drug to market. The survey and in-depth interviews revealed three major trends that will typify next generation pharmaceuticals.

Drug discovery and development will focus more on biology than chemistry.

Drug markets will be more demand led than supply led.

The pharmaceutical industry will become more networked and horizontal.

Between these three trends, survey participants and industry insiders expect pharmacogenics to change how the pharmaceutical value chain is organised, how clinical trials are conducted and how approvals are reached, and how the industry's risk and rewards are evaluated. ■

Canterbury Tale

The Canterbury branch held its first meeting for 2005 on February the 3rd. The 20 fortunate people who attended were once again well fed and watered courtesy of Eurest NZ Ltd in the form of Ludovic Mahu.

Guest speaker John Clark held our attention with his presentation on "Preparing leaders and managers for health reform: the NHS Experience." John is the Director of Graduate Schemes, Gateway to Leadership Programme and International Relations for the NHS Leadership Centre, Modernisation Agency of the Department of Health (England). Despite (or because of) that awesome epithet, John proved to be an extremely knowledgeable and able speaker.

John began by putting the modernisation of the NHS within a wider context and made comparisons between the old NHS and the new - a move towards flexible professionals, longer term planning, multiple providers and patient and referrer choice.

1948 Model		New Model	
Staff	Rigid professional demarcations	Staff	Modernized flexible professionals benefiting patients
Patients	Handed down treatment	Patients	Choice of when and where get treatment
System	Top down	System	Led by front line
Appointments	Long waits	Appointments	Short waits, booked appointments

John outlined the NHS environment. A sector with a £75 (NZ\$198) billion turnover; 1.3 million staff; 301 primary care and care trusts; 123 acute trusts; 45 mental health/ community trusts; 31 ambulance trusts; 28 strategic health authorities; comprehensive, needs based and funded from general taxation.

The vision of the Leadership Centre is the continuous improvement of health and health care through developing leadership capacity and capability.

The Leadership Centre was set up in 2001 to establish a culture of knowledge acquisition & dissemination; design, deliver and localise a range of development interventions; produce products & tool-kits to enhance expertise; and expand leadership and managerial capacity. Driven by a belief that better leadership brings better patient care, better health outcomes and improved working practices for staff, the Centre is on a transition path to a new National Institute of Learning Skills and Innovation (NILSI).

NILSI will bring about real improvements for patients by promoting and integrating innovation from within and outside the NHS; identifying, validating and propagating high impact practices; creating effective mechanisms for continued education and learning and building capacity and developing leadership excellence.

The Leadership Centre's achievements to date include; delivering leadership development to over 45,000 clinicians and managers; commissioning programmes from leading

I believe that public servants are working flat out but in a system that shrieks out for fundamental change....If we don't get the systems and structures right we will never get to the roots of the problem, only prune its visible branches.

The key to reform is redesigning the system round the user.
Tony Blair

edge partnerships in public and private sector; involving health professionals in developing clinical leadership programmes; developing an e-learning programme for nurses; and delivering team leadership development programme in support of service improvement strategies.

Programs have ranged from a diverse portfolio of development opportunities for CEOs, directors, non-executives through to increased numbers of graduate entry trainees in general, financial and human resource management. Current activities include building leadership capacity at all levels.

The Centre is commissioning research to develop the evidence base on leadership development interventions and undertaking evaluations of leadership development programmes and interventions to assess impact on: service improvement, individual capability and organisational performance

For those of us feeling a little green with envy, John left the best to last. The Centre is aware of the potential for international collaboration and is looking to develop peer international action learning sets for senior leaders, host study programmes to foster an exchange of ideas, curriculum, good practice and comparative evaluation and research.

Developing an international network is high on the agenda. John is responsible for international relations and as well as bringing people out from the UK he is happy to assist visitors to the UK in making the appropriate connections with managers clinicians there. His email address is John.Clark@dh.gsi.gov.uk

Overall a very interesting and well presented seminar and a great start to the year.

Michael Aitken FCHSE



Leadership qualities framework



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

February 23rd

@ The Neurology Room,
Clinical Education Centre, level
5, Auckland City Hospital

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

Prioritisation for a DHB -
Lessons from Sweden

David Sage, Chief Medical
Officer, Auckland DHB

Non Members Welcome

Cost

Members Free

Non Members \$25

Our seminar programme is
supported by



Profile

New National Councillor Phillipa Neads is Service Manager for Allied Health at Auckland City Hospital, leading a team of 190 FTE Occupational Therapists, Physiotherapists, Speech Language Therapists, Play Specialists and Social Workers who deliver care to both inpatients and outpatients from all areas of the new integrated Auckland City hospital.

Phillipa graduated as a physiotherapist in 1980, and has been fortunate to have a clinical career across several countries spanning every health setting from a paediatric tertiary acute hospital to a community based child development team. Phillipa began her Master of Health Science at La Trobe University, Melbourne and completed it at Auckland University of Technology with majors in Rehabilitation and Health Management.

Away from work and her contribution to the NZIHM Council she and her husband love travel, diving, wine and gardening, although not always at the same time.



2005 Branch Committee

Holding our AGM during a social mix and mingle in Bar 3 at Sky City Casino was a gamble that paid off with both a good attendance and range of high quality nominees for our Auckland Branch Committee.

Your 2005 Committee is:

Bruce Parkes	Chair
Fiona Ritsma	Secretary
Alan Johns	Treasurer
Trisha Dunn	
Sue Frost	
Jenny Mitchell	
Jacki Richardson	
Sue Shipperlee	
Gay Tozer	

Our Seminar sub-committee has arranged a diverse range of interesting speakers for our Branch Seminar Series. Don't miss these chances for networking and continuing professional education.

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