



RISK MANAGEMENT ROUND TABLE

Risk Management Round Table	1
Risk from a Global Perspective	2
Profile	3
Upcoming events	3

Responding to feedback from earlier sessions, the Branch's August seminar took the form of a led interactive group discussion. Lex Henry, a Minter Ellison Special Counsel in Public Policy, led the session with support from Wendy Brandon, a Partner at Minter Ellison. Lex, who is a Director of a number of Companies in New Zealand and overseas and was Managing Director of several public companies, was able to bring a Board Room perspective to our discussions.

In opening the discussion, Wendy suggested that, in recent years, Risk Management has become an issue of increasing relevance to the Health Sector in New Zealand. Reports, such as the Bristol report, have highlighted issues and increased emphasis on developing a "culture of safety". This "culture of safety" is a move towards looking for "root causes" of adverse events, particularly adverse events, which have occurred in the context of complex systems, rather than those, which are the result of individual error. It is increasingly recognised that very few accidents can be traced to a single cause.

Also, increasingly a "holistic" approach to risk management is being adopted as information and reporting systems appear to be fragmented. A "silo" approach to risk management has tended to keep adverse events hidden, so that the patterns of accident have not been identified or lessons learned. With the growing awareness of work done in other industries, such as nuclear power and aviation, the ways in which knowledge can be applied across a range of industries is being examined.

The move away from a professional approach to a commercial approach in medicine has its own risks that have only recently been acknowledged.

Points listed for discussion included:

- ✘ Clinical governance vs. corporate governance – is there tension?
- ✘ If so, where are the pressures in terms of day-to-day operational issues?
- ✘ Where do health managers "fit" in all this?
- ✘ What are the main risk issues managers think about?
- ✘ What is governance?
- ✘ Operational responsibilities, compliance programs and governance – what are the linkages from a risk management perspective?
- ✘ Where do we waste the most money? – Correcting the problem after the event? Before the event? Paying the insurers to reimburse us?
- ✘ If you have a CEO (Chief Executive Officer), a CFO (Chief Financial Officer), and a CMO (Chief Medical Officer) – then why don't you have a CRO (Chief Risk Officer)?



Lex Henry

During the discussion speakers spoke of the need in Risk Management to look ahead rather than behind. Risk Management was not disaster recovery or business continuity. Three areas of risk were noted. Compliance risk; operational risk – which included internal compliance; and governance. Lex expressed the view that governance should be focussed on strategic risk. The Board and managers needed to be aware of the strategic risks to the organisation, the potential costs, who was responsible for managing that risk and whether such risks could be transferred to a third party who is not an insurer, e.g. to a supplier, through internal management and self insurance or some other approach.

(Continued from page 1)

Human resources and facilities were seen as areas critical to an organisation yet not receiving the risk treatment their criticality deserved.

For Management there is a need for common definitions. Although we are awash with data, databases are seldom compatible. Through taking opportunities to mesh data, information should become available to identify and better manage key risks. The ability to see patterns of risky behaviour evolving and to correct such matters on a proactive basis was discussed. The concept of exception reporting was noted whereby the only data which was actively scrutinised was that which showed a deviation from the norm, e.g. significant variations to budget, slowness in taking certain action.

Issues identified at a Board level included a current lack of governance standards for DHB Boards. While the NHS has mandatory governance standards, in New Zealand the Minister believes "legislative requirements" provide sufficient guidance. Good governance works to the environment not to prescription. It was argued that good governance should also see a focus on the exceptions. The question is, what should be reported by exception in this context where the issues are strategic ones, rather than operational?

Reported by Bruce Parkes

Risk from a Global Perspective

The International transfer of risk in health systems features in an article "Globalisation and the Challenges to Health Systems" published in Health Affairs Journal 21(3):160-165, 2002 and available free on-line at www.healthaffairs.org

The article is based on a keynote address the authors Julio Frenk, the Mexican Minister of Health and Octavio Gómez-Dantés, an Assistant Director at the Ministry of Health, delivered at the Commonwealth Fund 2001 International Symposium on Health Care Policy: Health Care System Reforms and Strategies to Improve Access and Quality of Health Care for At-Risk Populations, 9-11 October 2001, in Washington, D.C.

They postulate that the shift of human affairs from the nation-state to a global perspective is changing the nature of health challenges. In addition to their domestic problems, all countries must now deal with the international transfer of risks. These new challenges demand innovative forms of international cooperation, which, if developed, may also help to reconcile general national self-interest with international mutual interest. Their paper discusses the possibility of using health as an instrument of foreign policy and of developing new forms of cooperation around three key elements: exchange of experiences around common problems, evidence on alternatives, and empathy.

They note that intense international contacts are not new; the forces of trade, migration, war, and conquest have long bound together persons from distant places. After all, the Greek philosopher Diogenes coined the expression "citizen of the world" in the fourth century BCE. The virtual annihilation of time and distance now has three million people travelling and the traffic on international telephone switchboards over 100 billion calls a year.

In health, all countries must now deal with the international transfer of risks. The most obvious case of the blurring of health frontiers is the transmission of communicable diseases. This is not a new phenomenon per se. The first documented case of a transnational epidemic was the Athenian plague of 430 BCE. The Black Death of 1347, which killed one-third of the European population, was the direct result of international trade. In the sixteenth century the conquest of the Aztec and Inca empires through the introduction of smallpox was an early example of involuntary microbiological warfare. The global influenza pandemic of the early twentieth century accounted for more casualties than did World War I.

New risk is created by the scale of what has been called "microbial traffic." The explosive increase of world travel produces thousands of potentially infectious contacts daily, and even the longest intercontinental flights are briefer than the incubation period of any human infectious disease. A Peruvian outbreak of cholera turned into a continental epidemic in a matter of days in the early 1990s. Drug-resistant strains of tuberculosis have travelled from detention centres in Russia to Paris in just a few hours.

The authors point out the ripple effects from one system to another. The globalisation of health goes beyond diseases and risk factors to include health care and its inputs. For example, careful regulations on access to prescription drugs in one country may be subverted when its neighbour allows the unrestricted purchase of antibiotics, thereby stimulating the appearance of resistant microbes that show up in the first country.

Besides the risks, there are also opportunities for global action. Interdependence has opened up new avenues for international collective action through sharing and comparing information. Increasing communication, in the face of the growing complexity of health systems, has made international comparisons more valuable than ever. Countries can benefit from shared learning. Initiatives, such as the effort by WHO to assess the performance of all 191 health systems of the world will identify relatively good and bad performances and thereby promote the international dissemination of good practice. This kind of comparative analysis has the virtue of turning information into a global public good.

Bruce Parkes



New Zealand
Institute of Health
Management
A Branch of the
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Executives

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Up coming Seminars

September 17th
At Marion Davis Library
Auckland Hospital Building 43
5.30 for 6 p.m.

Recommendations of the Bristol Inquiry

Presented by Hugh Ross,
Chief Executive, United Bristol
Healthcare Trust

October 24th

At Minter Ellison Offices, Level
24, BNZ Tower Building, 125
Queen St 5.30 for 6 p.m.

Health Priority Setting

Presented by Tim Tebensel
Auckland University
Light refreshments supplied

Non Members Welcome

Cost:
Members \$20
Non Members \$30

Profile

Auckland Branch secretary Ian Wolstencroft was born in Melbourne, but despite his Australian heritage supports the All Blacks.

He commenced his Health Service career in 1963 when he joined the staff of what was then one of Melbourne's largest teaching hospitals - Prince Henry's Hospital as a trainee administrator. (20 years later he was a party to that hospital's demise)

After 19 years in rural Victoria where he was involved in the building of the Latrobe Valley hospital at Moe (this hospital was also recently closed) and other building ventures in East Gippsland he was appointed Executive Director of Western Hospital to not only oversee a major restructure to a 2 campus teaching hospital but also its \$AUD150 million capital spend.

In 1995 he was "lured" to cross the ditch (by promises of, he says, wine, women and song) to join Auckland Healthcare firstly as General Manager of Auckland Hospital and later in his current role of Project Director to the buildings of Auckland City Hospital and Greenlane Clinical Centre.

Besides his Auckland branch duties, Ian is a member of the NZIHM National Committee.



Hugh Ross Presentation is "Not to be missed Occasion"

The United Bristol Healthcare NHS Trust is one of the largest hospital and community service NHS Trusts with 9 hospitals, 7500 staff and a budget of £200m per annum. The Trust is the major NHS teaching and research centre for the South West of England with over 3 million people in its catchment area. Hugh Ross took over as Chief Executive of the Trust in October 1995. His key role has been to lead the Trust through and past Medical Council investigations and a Public Inquiry into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995. The Public Inquiry's damning report, issued in 2001, identified systematic failure through a lack of teamwork and leadership for the failures at the hospital. The Inquiry's report contained close to 200 recommendations. Hugh, with a long standing commitment to the performance management of clinical services and a philosophy of continuous process improvement has been well equipped to make the necessary changes. Hugh is a dynamic and inspirational leader. His presentation at our September seminar is a "not to be missed occasion".

Conference Material Now Available

Those who attended our July Conference were promised electronic copies of Presentations would be made available. Richard Penny now has electronic copies available. If you would like a copy please contact Richard at r.a.penny@xtra.co.nz