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Do governments have the capacity to reallocate health resources to meet policy goals?

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The teaching part of my job involves teaching courses in public policy and public sector management. In this area of study and research, there are no 'grand theories' of how policy works, just a set of insights and perspectives about what does happen and what should happen. What I want to do is to 'boil down' some of this thinking in order to suggest a framework for thinking about the capacity of governments to do the things they want to get done. I want to explore the issue of policy capacity using priority-setting in health as my example. Among my current research activities I am involved in a project studying the implementation of the DHB structure and my particular interest is in issues of resource allocation or priority-setting. I've been looking at the issue of health priority-setting since about 1998 - My initial interest was spurred by the HFA document that asked the question 'how shall we prioritise health and disability services?'

But first, I will take a short detour into the bigger picture of health policy reform. One of the big themes of the managerial revolution in public sector management of the 1990s was the theme of 'letting managers manage'. This required that governments give managers the authority to go out there and get results

In the redesign of the state sector, an enormous amount of thought was put into the design of authority structures in the public sector in NZ. This was possible because the institutional structure of NZ government meant that things could be reorganised on a grand scale. However, I think one of the characteristic shortcomings of public policy reformers of all stripes is the tendency to confuse authority with capacity. There has been a tendency to say "If we build it, they will come". No doubt it is important to think about formal structures of authority.

But, for example, the fact that the Chinese Communist Party had the power to authorise such initiatives as The Great Leap Forward and the Cultural Revolution was not much help in achieving the objectives they set out.

The concept of government capacity is a crucial one in my area of study. So I want to suggest a way of thinking about capacity that could be useful for those working at the coalface of getting things done.

Its useful to think of capacity as the *mobilisation* of two things: knowledge and power. Of course, knowledge and power are always intertwined but there is something to be gained from thinking about them separately. In most health policy issues significant policy changes of any sort are unlikely if governments aren't able to mobilise both knowledge and power. Mobilisation of knowledge and power is possible when there is not too great a distance between 'what ought to be' and 'what is' and where power and knowledge work together. Policies fail when knowledge capacity is lacking - that is the difference between 'what ought to be' and 'what is' is too great; where power



Tim Tenbense

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LAWYERS

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capacity is lacking; or where knowledge and power do not match.

I take it that you are all familiar with the notion of explicit priority setting. Advocates of priority-setting claim that health resources are inherently limited regardless of the level of health funding. Many publicly funded health services are difficult to justify (e.g unnecessary, ineffective, not value for money). Clinical autonomy over resource use is a key obstacle to more rational allocation of resources. A key reason given for this is that those who control the demand are not responsible for paying for it. Implicit priority setting, (the status quo), cannot deal with pressures on health budget such as escalating drug costs. Therefore it is important that priorities are set explicitly.

So, if governments want such prioritisation to take place, what is it that they need to know about? Any discussion of priorities involves discussion of values – deciding which criteria are important in setting priorities. Typical candidates include effectiveness, cost, equity, importance to Maori and community acceptability. These are the things that policymakers need knowledge about. There are countless ways in which we *could* know about these things. For instance, effectiveness can be explored using techniques from demography and epidemiology, (Health Needs Assessment), from health economics (cost-utility analysis), from clinical research trials, from asking clinicians what they think is effective based on their experience, and by asking the general public what they think is effective.

Of course, depending on how you investigate effectiveness, you are likely to come up with somewhat different answers. Typically, policymakers make decisions about which types of knowledge should be regarded as relevant and which types should not. So, clinical research trials are regarded as more relevant than asking the general public. Going through the list of criteria, the same will apply to cost, community acceptability, equity and importance to Maori. There are different ways of knowing these things and some sources of knowledge are given credence over others by policymakers when they try to establish what types of knowledge *ought to be* relevant.

In priority-setting, typically there is a great deal of discrepancy between statements of what *ought to be* relevant and what *is* relevant in determining whether health services are effective. More often than not, these decisions are made in our health system under the rubric of clinical autonomy and this framework of judgement produces different priorities than those that would be produced if, say, health economics techniques were used to define effectiveness. The other reason there is a large gap between *what is* and *what ought to be* is that the types of knowledge that policymakers prefer may be too hard to get, or may be too unreliable. For example, not all health services can be studied in terms of clinical research trials in order to judge their effectiveness. Finding out what the community values and finds acceptable is notoriously difficult methodologically.

Then there is the issue of how policymakers deal with different types and different sources of knowledge. This has also been a thorny problem for those who favour explicit prioritisation. For example, even if health managers do find a consistent way of comparing different health services in terms of effectiveness and community acceptability, how do they 'boil down' these different types of knowledge? In the case of priority-setting, when policymakers do think about this, they come up with some fairly crude mechanisms, such as 'weighting' different criteria – e.g. 30% for effectiveness, 15% for acceptability. The HFA's 1998 document on prioritisation thought that most of the tools for assessing cost, effectiveness and equity and community acceptability could come from the toolkit of health economists. Such a statement of *what ought to be*, an approach that seemed conceptually practical, but highly exclusionary of other ways of knowing about these criteria. Furthermore, as a way of determining priorities in health spending it bore virtually no resemblance to current practice – the gap between *what is* and *what ought to be* was clearly enormous. As such, the HFA did not have the knowledge capacity to implement its vision.

Turning to power capacity, a fundamental question to ask is 'what are the power relationships that affect priority-setting in health?' One thing political scientists agree on is, when looking at health, medical professionals are structurally powerful. This would be of no surprise to managers in the health sector. Policy reform is often about changing

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formal structural relationships. Governments typically adopt structural reform in an attempt to change the deeper power structure. When policymakers attempt major reforms, they need to have a clear view of which policy actors are involved in policy, and which are the most powerful. This can then be contrasted with who they want to be involved and who they think should be powerful. Lets imagine that policy makers actually were able to solve the technical problems of priority setting about how to measure all those values of cost effectiveness and equity and actually figured out a way to put them together. The implications of such a policy framework, however, are profound in terms of power relationships. In order for such an approach to priority-setting to work it would necessarily require a significant relinquishing of power over the allocation of health resources from the medical profession. Most approaches to explicit priority-setting do not suggest how this could be achieved in practice.

Now lets look at some familiar things in New Zealand and start with something that has been a policy success, at least in terms of the government's objectives. I want to start with Pharmac. It has been successful by and large because for its knowledge capacity it clearly set out the criteria it wanted to use, such as cost and effectiveness and they can measure and assess different products in terms of those criteria. Pharmac has decided that it wants to assess new drugs in terms of a health economics based cost-utility approach. For pharmaceutical products this approach is more feasible than it is in other areas of health spending. Therefore the gap between "what ought to be" and "what is" is manageable.

Turning to power capacity, Pharmac has power as a monopsonic purchaser, that is, it is the dominant or only purchaser. This puts it in a strong market position and countervails pharmaceutical business power, although the mobilisation of this power has some side effects elsewhere. Although, government does pay a political price for freezing out pharmaceutical companies, power and knowledge match up reasonably well in the case of Pharmac.

This contrasts with the situation faced by DHBs (and the RHAs and HFA before them) where most of the criteria suggested for priority-setting are difficult to define and the definitions (like acceptability) are contentious because the complexity of the task of comparing health services across the board rather than a particular type of health service is enormous. Management does not necessarily have the capacity to get the information they need in a form that is digestible – therefore the gap is enormous. And even if knowledge issues could be managed the mismatch remains between knowledge and power.

Lets now look back to the managerial reform of hospitals between 1993-99. This is where reformers thought a lot about power and ways to change the power structure. They sought to close gap between what ought to be and what is, by taking on the medical profession. They did this through a whole series of measures such as having managers run hospitals instead of medical professionals. This attempt met with much less success than in other areas where this was attempted.

The important thing here is that what ever happened with power, reformers were hampered by huge gaps in knowledge. They had given managers the formal power to manage but they did not have access to the knowledge they needed. Many of the available measures were crude so managers were faced with a knowledge vacuum. So the power shift, what there was of it, was not accompanied by necessary changes in knowledge. This, in turn, meant that the newfound power of managers could not be effectively mobilised.

What implications does this have for public sector health managers? Managers in the public sector are required to do what their political masters have decided but an important part of their role is to advise those same political masters on the feasibility of policies. In health, complexity of knowledge is one of the key issues faced by managers. Reform approaches that give predominant weight to a particular type of knowledge are likely to run into difficulty.

We should think in terms of power structures as not just relationships between players. I think it is important to build it into policy design and do it simultaneously with thinking about knowledge so that power and knowledge do match. That is to try to ensure that the gap between *what ought to be* and *what is*, is manageable. While this could be a recipe for conservatism, it need not be, and there is a large body of material available in policy

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studies that suggest that incremental approaches are effective way of getting places and I think that is particularly applicable to health than most other policy areas.

What we have had over the past 15 years in New Zealand is managers being asked to do the impossible and I think it is reasonable to expect managers to tell their superiors and political masters. I am not in a good position to advise managers and DHBs on how to go about helping their masters discern what is and what isn't possible, as I do not claim any expertise there. However I hope that some of these ideas might be a useful way of thinking about big picture.

This paper was drawn from Tim's presentation to our October Minter Ellison Branch Seminar

What we have had over the past 15 years in New Zealand is (health) managers being asked to do the impossible .

Book review

Elephants and Fleas: Do women make better fleas?

Charles Handy has built his current status as one of the pre-eminent social philosophers and business gurus of the late 20th Century on a series of publications with a tone that is at once learned, genial, witty, and wise. *The Age of Unreason*, *The Age of Paradox* and *The Empty Raincoat* were, for me, fascinating reading. Handy is a master of powerful quirky metaphors, such as, "the shamrock organisation", 'the inverted doughnut", "the sigmoid curve principle" and "going portfolio", a term he coined for what he believed would be the trend for many workers going into the twenty-first century. That of being self-employed, part-time, or temps of one sort or another, with a portfolio of many skills and a collection of clients needed to make a living.

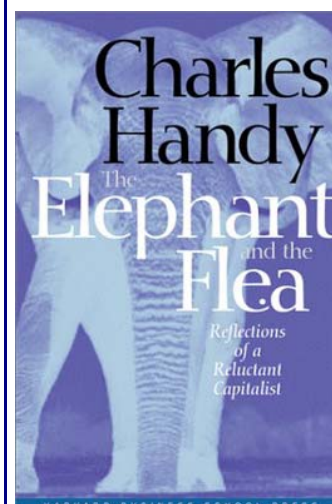
When recently interviewed by Linda Clark on Nine to Noon, Handy locked in listener's attention by offering a comment that women make better fleas than men but (isn't there always a but) as women moved deeper into the corporate world they were losing that comparative (competitive?) advantage.

Handy was using the interview to promote his 13th book *The Elephant and the Flea*, an autobiography-laced analysis of business over the past two decades. Handy is always a delight to read and in this book he looks within and at education, marriage, religion, and society in order to assess the changing nature of employment. His literate and knowledgeable tale begins in 1981, when Handy decided to exchange a safe but stifling life with a corporation (the "elephant" of his title) for the riskier but potentially more rewarding existence of an independent (or "flea").

In this book Handy takes us on his life's journey, looking back to such topics as his childhood in an Irish vicarage and education at Oxford University and how they prepared (or, rather, did not prepare) him for a career in business; the changing nature of organizational life within the context of the old economy and the new; the great variety of capitalism around the world; and, through it all, his struggle to find meaning and fulfilment in work. *The Elephant and the Flea* is a fitting capstone to Handy's brilliant career and colourful life.

Handy uses the quirky, powerful metaphor of the elephant and the flea to describe and critique the great shift from the prevalence of behemoth, slow-moving, bureaucratic organizations that provided a lifetime of security and not much freedom or room for creativity, to a world in which we are much more independent and flea-like, flitting from job to job, latching onto elephants when we need to, but mostly flying solo and without safe havens. Is this an apt analogy for our health

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system, where we are all fleas hopping on and from whichever elephant current government policy has lumbering past us?

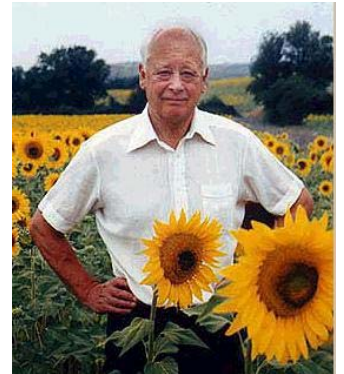
Mixing diverse experiences with cogent observations on the evolving workplace, he sets the scene for plausible projections about where we might yet be headed. "Just as the signs were there 20 years ago for those who wished to see them, so I believe we can glimpse the shape of the new capitalist world even if it may take another 20 years to develop," he writes. "We may not like what is coming but we would be foolish to think that we can plan our lives, or our children's lives, without giving some thought to the shape of the stage on which we and they will be strutting."

Reflecting on his love-hate relationship with government and big business, Handy waxes on the wealth disparity created by capitalism, the superficiality of the so-called new economy, and the balance of freedom and loneliness that comes with living the portfolio life. He comments that currently elephants seek growth by merging or swallowing each other. An approach he sees as doomed to failure. Elephants need fleas, both inside and outside the organisation to provide the free thinking and inspiration so essential for sustainability and growth.

Back to the Linda Clark interview. Handy was lauding the ability of women to multi task in successfully coping with families, careers and contributions to their communities. That multi tasking ability gave them a distinct advantage as they moved from project to project as corporate elephants ponderously changed direction. However, Handy saw this advantage disappearing as women moved into the corporate world in comparative numbers and levels to men. Once locked into the corporate world he saw their multi tasking skills dropping to a similar level of men. Breaking through the glass ceiling might not always be an advantage.

The Elephant and the Flea is available now in hardback and a paperback edition is scheduled for release early in 2003. Handy is scheduled to speak at a half day workshop in Auckland on December 16.

Bruce Parkes



Charles Handy

Strategic Planning 101

Start with a cage containing five monkeys. Inside the cage, hang a banana on a string and place a set of stairs under it. Before long, a monkey will go to the stairs and start to climb towards the banana. As soon as he touches the stairs, spray all of the other monkeys with cold water. After a while, another monkey makes an attempt with the same result all the other monkeys are sprayed with cold water. Pretty soon, when another monkey tries to climb the stairs, the other monkeys will try to prevent it.

Now, put away the cold water. Remove one monkey from the cage and replace it with a new one. The new monkey sees the banana and wants to climb the stairs. To his surprise and horror, all of the other monkeys attack him. After another attempt and attack, he knows that if he tries to climb the stairs, he will be assaulted.

Next, remove another of the original five monkeys and replace it with a new one. The newcomer goes to the stairs and is attacked. The previous newcomer takes part in the punishment with enthusiasm! Likewise, replace a third original monkey with a new one, then a fourth, then the fifth. Every time the newest monkey takes to the stairs, he is attacked.

Most of the monkeys that are beating him have no idea why they were not permitted to climb the stairs or why they are participating in the beating of the newest monkey. After replacing all the original monkeys, none of the remaining monkeys have ever been sprayed with cold water. Nevertheless, no monkey ever again approaches the stairs to try for the banana. Why not? Because as far as they know that's the way it's always been done around here.

And that, my friends, is how a company policy begins.



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Profile

Sue Frost, who holds a BHSc(Nursing), has worked within the healthcare environment for many years. Her speciality is Operating Rooms, mainly in Neurosurgery and she has extensive experience in both United States and New Zealand environments. Sue has held clinical leadership positions in Operating Rooms with Auckland Healthcare and Mercy Hospital, Auckland.

Sue moved on from her clinical roles to positions with Baxter Healthcare as Divisional Manager of their Operating Room Division, first in NZ and then Australia. After 3 years with Baxter Sue returned to a hospital environment 18 months ago by taking up the position of Hospital Manager at Southern Cross Brightside.

Sue injects both humour and wise counsel into Branch committee deliberations. She comments, "I enjoy the opportunities provided by the NZHIM, for growing my knowledge across the sector, broadening my information base and also networking both with other providers and also in the surrounding dimensions of health. I continue to admire the diligence in which people within health manage the complexities, challenges and ongoing restrictions they face. I enjoy being involved on the committee side of NZIHM. For me it is a challenge to see how we can broaden our collegial group and enhance their involvement into their own and others futures."



Up coming Seminars

We have a full programme of
Branch seminars for 2003.

February 26th

Organisational Development of New Zealand Blood Services

Jenny Mitchell, Peter
Flanagan, Judith McMorland
@ N.Z. Blood Service

Non Members Welcome

Further information in Inform 7
and by a special flyer to
members



The Auckland Branch Committee extends Season Greetings to all our members. We wish you and your families a joyous Christmas, a break from the daily pressures of work and your revitalised return to the challenges of 2003 when all your New Year resolutions will be achieved.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at nzihm@xtra.co.nz