Inform

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The future of contracting: alternative models to competitive tendering

This paper is drawn from a presentation Peter Glensor gave to the Health and Disability NGO-MoH Forum at Auckland in April this year.

I offer these thoughts on contracting wearing two hats. First, I am Chair of the Hutt Valley District Health Board, with a budget of around $300 million of public money. We are charged with three main tasks:

To improve, promote and protect the health of communities; To reduce health disparities by improving health outcomes for Maori and other population groups; and to Foster community participation in health improvement, in planning for and changes to the provision of health services.

The main way we do this is through funding the provision of health services – through our own provider arm – our hospital, Community Nursing and mental health services, and our Public Health unit; through the payments for demand driven services – pharmaceuticals, laboratory tests; through primary and community health services – PHOs, palliative care, health promotion, Maori and Pacific health services, mental health and addiction programmes; and through aged care and mental health residential or hospital services

Given this responsibility and the fact that we are spending public, taxpayer, money on behalf of the Crown, I have a high interest in ensuring that the money is spent effectively, and that we can account fully for its use.

As Colleen Pilgrim, Sector Manager for Health and Primary Production, said in November 2005, in a paper prepared for the Office of the Community and Voluntary Sector's *Good Practice in Action* conference **What does the Auditor-General expect of the funding arrangement?,** the Auditor General expects that our funding arrangements are:

- Based on principles of good management of public resources
- Public resources for the public benefit: accountability, transparency
- Equity and fairness
- Meets public standards of competence and integrity

Recently, our DHB went through the difficult process of cancelling a contract with an NGO provider. This followed many months of dialogue and interaction with that provider. At the end of that process, we concluded that the provider was not providing the services in a quality or quantity that was satisfactory, and that they were not going to be able to “raise their game”.

It’s a tough call.

The second hat I am wearing is as Co-Chair of the Community Sector Taskforce. That’s a group of ten people, working on behalf of the whole of the tangata whenua, community and voluntary sector, to continue work which began in 1999. We aim to bring together the

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whole sector, to raise the profile of the sector, to strengthen the capacity of the sector, and to strengthen relationships between the sector and the state.

We have been enormously grateful for the support of the Health and Disability NGO Working Group, who have attended all our key events, and have sent out material on our behalf to the health and disability NGO networks.

Recently, at a Research Forum convened by ANGOA, we heard of research being done by Massey University about how the contracting environment is impacting on Maori health providers. What we heard is repeated constantly throughout the sector. The contracts, while being the source of funding for our work, actually get in the road of us delivering on our kaupapa. We become focused on what the contract requires of us, which may not be the same as the needs of our community. We must count numbers, in order to report on those numbers, and that means we can't always respond appropriately to the living situation of people.

These concerns echo strongly for me, and for the Taskforce. They have a strong resonance for me from my previous work as a local and national NGO leader in primary health. So, I thought I would share a few thoughts about it.

I'll start with a confession. I think we were partly responsible for the emergence of contracting in the 1990s!!

I recall how the national network of eight Union Health Services in the early 90s entered into dialogue with the then Dept of Health. We were running capitated practices serving very high need, and very low income populations. The Dept of Health was very sympathetic to our situation, since it was obvious that the service we provided was desperately needed, and well regarded. We said to them, "We would like additional funding from you. We are happy to provide you with information about what we are doing – the numbers and types of people we are seeing, the services we are providing, and so on. We see you – the government – as our natural allies, and we suggest that our relationship of mutual trust and respect could be formalised through some form of written agreement. In exchange for X dollars, we'll provide you with information."

The Dept was very interested because they were working in a virtual information desert – they knew almost no details of what was happening in General Practice, despite paying out many millions of dollars in subsidies.

We also talked with them about a change in the funding arrangements for maternity care. Rather than paying us for specific items of service by GPs or midwives, we proposed a bundling together of services, with a single payment for each trimester we cared for a woman before, during and after her labour. Again, this proposal was mutually agreed and willingly entered into.

Fifteen years later, we have this contracting as the normative – probably the only – mode of funding of health services. Maternity are now funded exclusively by single payments covering the whole process of ante-natal, labour, and post-natal care.

And the system is characterised by greater or lesser degrees of mistrust, complicated processes of auditing and monitoring, enormous transaction costs for both funders and providers, and a lingering suspicion of malfeasance.

NGOs are told one day they need to cooperate and collaborate - the next that they must submit a competitive tender, when they don't know who else is tendering, or at what price. In my region, for example, I watched the Pacific community being torn apart by these processes, setting group against group.

Something has gone wrong, and new modes must be sought.

What's the problem?

To start with, I believe the whole nation remains in the grip of some philosophical ideas which underpin contract theory, and various other esoteric economic theories.

Central to these, is the belief that people are selfish, will always pursue their own interests, and will try and cheat the system if given the chance. (I was told this at a Greater Wellington Regional Council meeting, by a submitter, suggesting that Senior Citizens would rob other people's Superannuation Cards to get cheaper bus or train fares!) This belief means that systems must be set up to minimise the danger of "cheating" or "theft". It means that funding relationships must be in writing, and must provide maximum protection that people won't just take the money and run, or take the money but not produce the goods.

For the NGO sector – I believe for the whole nation of Aotearoa/NZ – this assumption is not in fact true. Yes, there are rogues – there always have been. But our whole society is actually based on the assumption that people will adhere to certain rules, will comply with agreed limitations, and will cooperate with one another for the common good.

The system is characterised by greater or lesser degrees of mistrust, complicated processes of auditing and monitoring, enormous transaction costs for both funders and providers, and a lingering suspicion of malfeasance.

. . . . . .

We are building, within the NGO sector, a whole new class of people who see the state as the enemy – the funder as an opponent, who must be appeased, worked around, and sometimes lied to.

The sad result of the last decades of contractualism is that we are building, within the NGO sector, a whole new class of people who see the state as the enemy – the funder as an opponent, who must be appeased, worked around, and sometimes lied to. Audits and monitoring are not opportunities for mutual learning and development. They are exercises in one party trying to find out how bad you are, and the other party trying to hide any non-performance. I think it's time to have a much more open discussion about whether it's possible to do things differently, and try those ways.

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Can I tell another story, to show that it is possible to do things differently? In 1998 the then Minister of Health, Bill English, authorised a grant of $1 million to Health Care Aotearoa. We were to use this money to make grants to groups who wished to set up community-owned and driven primary health services serving high needs populations. In the end, from memory, seven new services were established with support from that fund – in Whangarei, Auckland, Gisborne, Masterton, Wainuiomata, and Christchurch (and somewhere else – I think Hawera!).

From the beginning, we agreed we would distribute that funding, not using a competitive framework. Rather than putting out an EOI or RFP, with a deadline, we invited groups to approach us when they felt they were ready. We set out some standards against which we would test the group, and their proposal – judging each one on its own, not against one another.

The testing of each proposal was undertaken by people who were experienced in community owned primary health services, and the final decision was made by a group of HCA members. As I said to the Minister, "Our bullshit detectors are better than anyone in government."

We accepted that some groups who were more advanced would get funding and that others would miss out because they were not yet ready. We accepted that there were many new initiatives which were, in their own right, extremely worthy, but would not be funded because they did not fit the fairly tight focus on community-owned comprehensive primary health services.

I believe that this programme showed an extraordinary level of faith on the part of the Minister, and demonstrated that it was possible to do things differently. In the end, of the seven – one General Practice fell over (but continues with a wide range of community health services within a PHO), one has become part of a PHO without achieving its own goal of including General Practice in its services, and five continue to work, also as part of PHOs.

I believe the nation got pretty good value for its money.

I have the sense that the government in general is ready to explore new ways of working. One important new factor is the talk of "joined up funding", "whole of government" programmes, and especially "funding for outcomes". As long ago as July 2004, Colleen Pilgrim and Robert Buchanan, of the Office of the Auditor General, wrote a paper entitled Risk based approach to contracts In that, they say,

"Use of the contracting model is nevertheless problematic for a number of reasons. For example:

> • specification of services and quality measures is difficult, especially for services that are intangible;
>
> • lack of specificity of outcomes makes evaluation difficult: "whole of government", collaborative or partnership emphasis in some contracts only adds to the difficulty of evaluation"

If you have an outcome like people living two years longer, how can you possibly write a contract that anyone would sign? Yet, having people live two years longer is exactly the kind of outcome we as DHBs and you as NGOs wish to see.

What we need are some new relationships, based on mutual respect, shared goals, and trust. Out of this may grow funding relationships and accountability regimes that are rigorous, professional and even tough – but are above all, real.

I see the NGO sector as the ideal partner for the government in this venture: this is the sector where innovation and risk-taking happen; this is the sector where people have a real passion for making a difference; this is the sector where there is a long history of getting value for money; this is the sector with strong community connectedness.

In summary, I'm keen to open that dialogue in a tangible way. I believe that now is the time to try something new.

We can work towards new funding relationships where the focus is:

- outcome-based funding
- relationship-based funding
- no lawyers!
- a greater stress on personal accountability, on the part of the people who are involved.

Thank you for the chance to share my ideas. #

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 admin@nzihm.org.nz

Report on New Zealand Non-Profit sector

The non profit sector makes a significant contribution to healthcare in New Zealand. Do you agree? Well yes . . . but what is the not for profit sector? Good question – the Johns Hopkins Comparative Non-profit Sector Project (CNP), partnered in New Zealand by the Committee for the Study of the Non-Profit Sector in collaboration with the Office for the Community and Voluntary Sector (within the New Zealand Ministry of Social Development) and utilising a research team drawn from Massey University is trying to find out.

The CNP has been recognized as the first systematic effort to analyze the size, scope, structure, financing, and role of the non-profit sector in a cross-section of countries around the world to improve understanding of this sector. It will hopefully serve as a useful foundation for other steps expected in coming years in the world of research and action concerning non-profits. The project's report is available on line at www.ocvs.govt.nz/work-programme/non-profit-study.html

There is no single agreed term that fully describes the non-profit sector in -New Zealand. Rather, a number of terms are commonly used that refer to all or part of it. The application of these terms to organizations and to fields within the sector can overlap and sometimes terms are used interchangeably. The most frequently used terms are non-profit (or nonprofit or not-for-profit), voluntary, community, voluntary welfare, nongovernmental, third sector (sometimes fourth), and independent sector. There can also be differences between the terms organisations use to refer to themselves, and those others use to refer to them. For instance, the Ministry of Health uses the term NGO to refer to all health groups that are non-statutory and non-profit making, but not all of these organizations will necessarily refer to themselves or the sector of which they are a part in this way, some preferring the terms community, voluntary, or non-profit.

Further complicating the issue, groups may be legally constituted as non-profit making but do not necessarily see themselves as part of the non-profit sector. The diverse and varied organizations that take the non-profit legal form cannot be easily described as a single sector with a common sense of purpose and shared values. Many organizations that would be defined as non-profit organizations because of their legal status are more likely to identify themselves as belonging to that part of the social, cultural, sporting, economic, or political sector that they serve.

The terms used to describe these organisations are often used interchangeably or bracketed together, indicating a strong overlap among them. NGO, non-profit, community, voluntary, voluntary welfare—are all used in varying combinations, and in an overlapping way, to refer to groups active in the social, health, education, advocacy/change, and development areas.

While there is a strong tradition of individuals joining formal and informal organizations, volunteering, and giving in New Zealand the tradition of corporate and large philanthropic giving is less well established. In New Zealand there is a strong focus on the contribution that government is expected to make to non-profit organisations.

The report identifies diversity and constant, dynamic processes of change characterising the non-profit sector in New Zealand. The non-profit sector is seen as energetic, innovative and vocal, offering rich opportunities for citizen engagement. Iwi/Maori organisations were found to be active in all fields of the sector and in addition to this, a range of organisations also provide stewardship over the affairs of iwi in perpetuity. While iwi/Maori organizations generally draw on both Maori kaupapa and Anglo-Saxon traditions, it is these tangata whenua governance organizations that bring a distinctive New Zealand flavour.

The particular closeness of relations between the non-profit and state sectors creates both challenges and opportunities. There is a tradition of dialogue and the non-profit sector has not been backward in taking a stand on critical issues facing vulnerable populations, the country as a whole, and sectoral groups. At the same time, many parts of it, most especially those delivering social services, have become significantly dependent on state funding. Tensions have increased along with this dependency.

The state, particularly in the past three decades, has utilised a willing reservoir of energy and structure through which it has been able to pursue some of its key goals by purchasing services and expertise directly from the sector. The experience since the state sector reforms of the 1980s and the transformation of state support for the sector from grants-in-aid that assisted organisations to achieve their own ends to contracts purchasing services on the state's behalf, reflect a significant shift in the way in which the state understands the sector.

The sector reflects and represents diverse citizen interests and these are not always consonant with the interests and needs of the state. As the state increasingly contracts with sector organizations to deliver services, tension between government interests and those of the sector become more apparent. While the current discourse is of partnership, it is clear that further work needs to be done to achieve relationships based on mutual understanding and respect.

Margaret Tennant, Jackie Sanders, Michael O'Brien, and Charlotte Castle. *Defining the Non-profit Sector: New Zealand*. Working Papers of the Johns Hopkins Comparative Non-profit Sector Project, No. 45. Baltimore: The Johns Hopkins Center for Civil Society Studies, 2006

Message from our President

I have recently returned from Ireland where I attended the 21st Congress of the European Association of Hospital Mangers, it was satisfying to affirm that the New Zealand health system has the same issues and challenges as our European counterparts. The theme of the conference was "Healthcare and Hospital Management in Transition" and reflected the changes taking place in most European countries. Globally healthcare is threatened by a confluence of powerful trends- increasing demand, rising costs, uneven quality and misaligned incentives. We must all explore the lessons and the solutions from around the world because if ignored these threats will overwhelm our health systems.

A way of increasing knowledge is to participate in the Fellowship programme offered to our members through the Australian College. Members who are eligible for advancement can approach the Fellowship process through a major oral examination or the submission of thesis, published papers and/or case studies.

Major oral examinations for eligible candidates are held each year in conjunction with College Annual Meetings and NZIHM National Conference. Alternatively, eligible candidates wishing to submit a thesis, published papers or case studies for consideration require ACHSE approval of subject matter chosen. Please check out the NZIHM web site for eligibility criteria and more information www.nzihm.org.nz/membership/Fellowship.asp

Pauline Barnett, on behalf of NZIHM is undertaking a Fellowship program in 2007 to prepare candidates for the oral examination. This is a structured program with supplied readings. Please contact Pauline directly pauline.barnett@chmeds.ac.nz if you think you are eligible and would like to advance your membership to the status of Fellow.

Following on from the success of our 2006 conference "Teaching Old Dogs New Tricks" (see web pages for copies of presentations) planning is now underway for a joint NZIHM / RACMA conference in September – October 2007. If you have heard an interesting speaker or would like a special topic covered please contact Linda in National Office (admin@nzihm.org.nz)

Planned for 2007 is a NZIHM National Learning Set facilitated by Anthea Penny. Please contact Anthea directly anthea.penny@xtra.co.nz

Leadership Programmes recently attended by national council members, which come highly recommended are the NZIHM National Health Leadership Program facilitated by Anthea Penny (www.rhpennyltd.com), a Leadership Development Intensive run by Robyn Wayne-Lewis of Core Consulting (www.coreconsulting.co.nz) and the Certificate of Applied Leadership run by Suzzanne Wilson of Leadership Unlimited (www.leadership-unlimited.co.nz) If you have attended a leadership or health management course which you would like to recommend let Linda know so we can inform our members.

Enjoy your learning!

Trisha Dunn

Fellow & National President NZIHM

Integrated Governance in the NHS-an Exotic Worth Importing? Is the subject for our final seminar of the year on November 28th. Our presenter will be Dr John Bullivant, Visiting Senior Fellow in Governance at the University of Glamorgan

John is an experienced facilitator, mentor and accredited project manager with a PhD on allocation and access to public resources. He is associate director of board development for the NHS Clinical Governance Support Team, a visiting senior fellow at the University of Glamorgan, Chair of the Health & Social Care Group of the Institute of Quality Assurance (IQA), a fellow of the Royal Society of Medicine and an elected member of their Quality Council and a member of the European Corporate Governance Institute.

John is currently involved as a special advisor in two assignments: To Northern Ireland to work with the Dept of Health & Social Care and the NHS Confederation on Board development; And to accountancy firm, Bentley Jennison, to further develop the integrated governance agenda.

He has 28 years' experience in the public sector with local government, the probation service, the NHS, the Audit Commission and the National Assembly for Wales.

In 2004 he completed a three month secondment to a Strategic Health Authority and has recently been developing and running Integrated Governance Development Programmes for NHS Boards in England, Wales, Scotland and Northern Ireland. With Professor Michael Deighan he is the author of the Department of Health publication '*Integrated Governance – a handbook for executives and non-executives in healthcare organisations*'

John has been an executive director and board member of a Health Authority, project director on VFM and overseas development projects, and a lead facilitator for local health boards in Wales. He is a writer and presenter on topics such as governance, leadership, performance management, public patient involvement, continuous improvement, partnership working and intelligent funding.

He was a member of the Audit Commission Ethnic Minorities Opportunity Mentoring Programme (OMP) which in 2003 won the gold standard in the International Standards for Mentoring Schemes in Employment Assessment.

He is a founder of the public-private sector Benchmarking Institute and author of many articles and books on continuous improvement including the Financial Times Report: '*Benchmarking for best value in the NHS*'.

He maintains an interest in the application of the business improvement models, multi-sector benchmarking, governance and patient advocacy.

Through the IQA, John has recently launched a Commission into 'Where is the Quality Framework for the NHS?'

United States falls short on key health-care indicators

Despite health expenditures that are twice those of the median industrialized country, a new national scorecard of U.S. health care system performance finds the nation falls short on key indicators of health outcomes, quality, access, efficiency, and equity. Findings, published as a *Health Affairs* Web Exclusive, paint a disturbing picture of missed opportunities, as well as evidence the United States can do better on all fronts.

The article, "U.S. Health System Performance: A National Scorecard" (*Health Affairs* Web Exclusive, Sept. 20, 2006), written by The Commonwealth Fund's Cathy Schoen and colleagues, presents the results of the National Scorecard on U.S. Health System Performance, the first of its kind to assess the country's health care system across all critical domains. The Scorecard was developed by the Commonwealth Fund Commission on a High Performance Health System, which has issued an accompanying report examining the results and their implications.

Overall score of 66/100

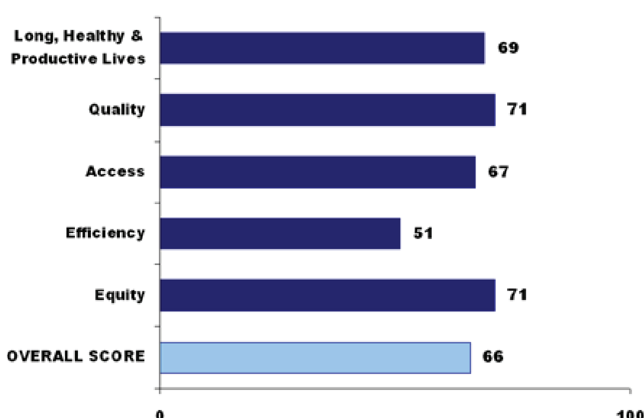
Overall, the U.S. health care system scored an average 66 out of a maximum 100, based on 37 indicators of health outcomes, quality, access, efficiency, and equity. National performance was measured relative to benchmarks based on rates achieved by top countries or the top 10 percent of U.S. regions, states, hospitals, health plans, or other providers. Relative to the benchmarks, U.S. performance averages near 50 for efficiency and around 70 for other domains.

To create the Scorecard, researchers used a framework developed by the Institute of Medicine and drew from indicators used by a wide range of experts, as well as new indicators designed for the Scorecard. The Scorecard will continue to monitor performance over time, with benchmarks providing targets for improvement.

Substantial Room for Improvement

A central goal of the health care system is its capacity to contribute to long, healthy, and productive lives. In the Scorecard, this goal is measured by a series of indicators on health outcomes like preventable mortality, life expectancy, and certain health-related limitations faced by adults and children. The U.S. scored 69 out of 100 in this area, with wide variations in performance seen across the country.

Among 19 industrialized countries, the U.S. ranked 15th on "mortality from conditions amenable to health care," or deaths before age 75 that are potentially preventable with timely, effective care. The U.S. rate was more than 30 percent worse than the benchmark—the top three countries. The U.S. also ranks at the bottom for healthy life expectancy and last on infant mortality.



Source: C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475.

In terms of access to care, including health system participation and affordability of care, the Scorecard revealed generally poor performance. The authors say this is primarily a result of rising rates of uninsured and "underinsured" Americans, as well as health care costs that are outstripping growth in median income.

In the area of health system efficiency, the U.S. scored only 51. Efficiency indicators illustrate that quality, access, and costs are interconnected: poor quality often contributes to higher costs (through higher hospital readmission rates, for example), and poor access undermines quality, while simultaneously contributing to less-efficient care. Efficiency scores also reflect the nation's low use of electronic medical records and relatively high insurance administrative costs.

Performance Widely Variable

Across indicators, there was often a substantial spread between the top and bottom group of states, hospitals, or health plans, with those at the bottom well below the leaders and the national average. For instance, patients discharged from the hospital with congestive heart failure receive written discharge instructions—a measure of well-coordinated care—only 50 percent of the time, on average. There is an 80-percentage-point spread between the top and bottom 10 percent of hospitals, with the top group at 87 percent and the lowest-performers at 9 percent. On certain indicators, simply raising the bottom of the distribution to average performance would yield substantial net national gains, the authors say.

Improving Quality and Saving Lives

Overall, the Scorecard makes a compelling case for fundamental change in the nation's health care system. In addition to saving lives and reducing preventable complications, a better coordinated, more accessible system of care could achieve substantial savings with a net gain in value. The Scorecard provides evidence that quality and efficiency can be improved together: more efficient use of expensive resources can produce the same or better quality care at lower cost.

Moving forward, however, requires policies that address the interaction

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Managing Health Services- Concepts and Practice 2nd Edition 2006

The very informative health management book written by Mary Harris in association with 40 health service management academics the Society for Health Administration Programs in Education (SHAPE) and the Australian College of Health Service Executives has recently been updated. The book provides a good coverage if management topics and issues faced by health managers and new concepts and strategies of multidisciplinary health service management and issues have also been included in this edition.

The book is divided into six parts with each chapter starting with a learning objective and ending with discussion question to facilitate group discussion. Case studies included within each chapter are now less Australian focused and can be easily read with a New Zealand focus.

Health service managers and the changing organisational context, also includes a chapter on accountability and ethics. One of the roles of the health manager is to create processes that aid in identifying, clarifying and rendering decisions on ethical issues that arise within the domains of research and patient care

Health service management practice-working with people; This is what health management is all about, ensuring partnerships with communities and consumers and working with health professionals. A chapter on change management asserts that the best outcomes depend on successfully merging the old with the best of the new.

Health service management practice – working with information, covers decision making and using information and knowledge. The importance of implementation and management of health information systems which support strategic management and organisational renewal is stressed.

Health service organisations, includes chapters on who does what in health care, current approaches to strategic planning and organisational design and the historic forces that have lead to fragmentation in the health service and ways to improve integration. Intelligent informed consumers and the inability of available resources to meet future health care trends are great motivators for ensuring we develop excellent quality and risk management systems

Improving organisational performance by integrating quality assurance and quality improvement is covered in the part five and includes an interesting chapter *From risk management to clinical governance*. New Zealand academics are found in chapter 18 with Nicola North and Rod Perkins's chapter on using research and evaluation in managing health services. The cultivation of research partnerships with mutually negotiated questions developed between researcher and mangers will lead to the health service having solid evidence on which to base future decisions.

The last section of the book has case studies in health service management from the Asia Pacific region

I found the book very easy to read and as it is divided into the six major themes, I found I could just pick it up and find another interesting chapter. While this book would be a 'must have' for anyone studying Health Service Management it is also a great refresher for those of us who might have completed their post graduate studies but need to continue to learn as health care trends and issues change so rapidly. I would highly recommend this book for all health managers as a useful reference and a resource for those tricky situations which often arise.

Trisha Dunn
Fellow and President NZIHM

While the concepts and practice of health management might be seen to be universal, most of the texts available to us are limited because they link to an environment distant to us in Australasia. Mary Harris and her associates are to be congratulated on producing a comprehensive 500 odd page volume filled with case studies to which we can relate. That is, if we are Australian. The "as" bit of Australasia is a little hard to find.

"Examples of Australia and New Zealand organisations that introduced TQM during the 1990s include Pirelli Cables Australia Ltd, State Bank of South Australia, VicBank, Accom Industries, Alcoa, Henderson's Automotive Ltd and the National Roads and Motorists Association."

Perhaps not surprising when almost all the forty contributors are resident in Australia and the prime audience for this book will be Australian health managers.

No one book can provide a complete answer to the needs of a health manager. I gave this book two tests: would it serve as a prime resource for a New Zealand health manager studying for their Fellowship; and was it useful as a resource to which I could refer others.

The first test was relatively straight forward. Harris has long been a prescribed text for Fellowship candidates. This edition continues the tradition of being the preferred starting point when investigating an area of management practice. A comprehensive list of references at the end of each chapter gives pointers for further detailed study.

For me, the lack of web based reference was a disappointment. For

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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

October 25th

@ Red Cross Offices, 2 Woodbine Ave, Green Lane

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

Complaints and Quality in New Zealand: The role of the Health and Disability Commissioner

Ron Patterson

Non Members Welcome

Cost

Members	Free
Non Members	$25

Our seminar programme is supported by:

MEDIREST
Caring Service, Smart Solutions

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those with ready access to a good library this will not be a major problem and one can "Google" to find a link but that can be an exercise in frustration and disappointment.

For my second test I used a junior colleagues request for material on sentinel event monitoring and investigation. On this I drew a blank. Proof that one book can not cater for all needs.

However, if you are going to buy one book on health management this is the book for you. A second alternative is to recommend your librarian secure a copy for your organisation's library. Then it will be readily available as a reference to provide authority and salient points for the persuasive report or business case you are sure to be writing—and yes it does describe writing a business case.

Bruce Parkes

Managing Health Services is available through the ACHSE website for just $NZ94.50

Ron Paterson, our October seminar presenter was appointed Health and Disability Commissioner for a five-year term in March 2000 and his term was renewed for a further three years from March 2005. He has law degrees from Auckland and Oxford Universities, and was a visiting law professor at the Universities of Ottawa and British Columbia in the mid-1980s, before returning to the University of Auckland as senior lecturer in health care law.

Ron has worked in mental health, public health, and consumer protection policy roles at the Ministry of Health, including as Deputy Director-General, Safety & Regulation. He has taught and researched in the United States, as Fulbright Visiting Professor of Biomedical Ethics at Case Western Reserve University and Harkness Fellow in Health Care Policy at Georgetown University.

Ron played a key role in the final development of the Code of Rights in 1996. He has lectured and published on a wide range of topics in health law, ethics and policy, and gave evidence on 'Safeguarding Patients' as an expert witness before the Shipman Inquiry in England in January 2004.

Ron has chaired two recent health system reviews in Australia: the Review of the Assessment of Overseas-Trained Surgeons; and the Review of Future Governance Arrangements for Safety and Quality in Health Care.

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of access, quality, and cost and take a strategic, whole-system view—rather than a fragmented approach to change. The authors conclude that investment in information capacity as well as guaranteeing affordable health insurance will be essential to progress. With cost and coverage vital signs moving in the wrong direction, say the authors, the nation's health system is in urgent need of transformation.

Facts and Figures

U.S. mortality for conditions amenable to health care is 115 per 100,000 people, compared with 80 per 100,000 in the top-performer among 19 countries.

Barely half of U.S. adults receive all recommended clinical screening tests and preventive care, according to national guidelines.

Thirty-day hospital readmission rates are more than 50 percent greater in those regions of the country with the highest rates than in regions with the lowest rates.

One-third of adults under age 65 are uninsured or underinsured. A similar proportion have problems paying medical bills or are in medical debt.

Disparities are pervasive: Black, Hispanic, low-income, and uninsured patients are less likely than white, high-income, and insured patients to receive recommended care, and more likely to be admitted to the hospital for potentially preventable conditions. #