

The Twenty-first Century Face of Senior Health Executives

Z Liang and C Brown

Abstract

Purpose: The public health sector in the State of New South Wales, Australia, commenced a major restructure of the roles of Senior Health Executives (SHEs) in 1989/1990. This study sought to investigate the demography, roles and responsibilities of SHEs within the New South Wales (NSW) Health Department (NSW Health) post-1990.

Methods: A postal questionnaire was administered to those employed as SHEs in New South Wales between 1990 and 1999 (accessible population 71, N= 29).

Findings: Data from the postal questionnaire found SHEs spent most of their time providing leadership, engaging in planning, liaising with external bodies, and monitoring and evaluating services and performance. A large proportion of SHEs had a tertiary qualification and felt that, in many cases, serendipitous events had contributed to their achieving senior positions.

Originality: This is the first study since the restructuring of the New South Wales public health sector in 1989/1990 examining the changing roles of SHEs. The findings of the study provide a foundation for further work with a focus on developing educational programs to enable the performance of roles required of health-care managers in the twenty-first century. This paper builds on previous publications that addressed the literature and qualitative aspects of the study. [1, 2]

Abbreviations: ACHSE – Australian College of Health Service Executives; CEO – Chief Executive Officer; NZIHM – New Zealand Institute of Health Management; SES – Senior Executive Service; SHAPE – Society of Health Administration Programs in Education; SHE – Senior Health Executive.

Keywords: health administration; restructuring; government employees; educational demands.

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Background

It has been argued that the traditional bureaucratic approach to public sector management is not working [3] as public sectors are required to improve performance and demonstrate greater transparency and accountability. [4] As a result, various corporate change strategies and private sector managerial models have been adopted by the public sector aimed at strengthening management capacity in government operations. [5] Healthcare restructuring has been a global phenomenon since the early 1980s as an integral part of public sector reform. [6] One of the most significant changes in healthcare was the adoption of private sector management principles and practices during the 1980s and early 1990s. [7] However, the implications of such strategies on the roles of Senior Health Executives (SHEs) have not been fully explored.

South Wales, the most populous state in Australia, has led the healthcare structural reforms in that country. [8] New South Wales had an estimated population of 6.5 million with approximately 72% of the population living in metropolitan areas, 20% in inner regional areas, and 8% in outer regional and remote areas. [8] The New South Wales public health system (NSW Health) is the largest healthcare employer in Australia, with almost 90,000 full-time equivalent staff.

New South Wales, structural reform in the health system was marked by the introduction of the area health management model in 1986, [9] which took more than ten years to implement in both metropolitan and rural areas. For the area health management model, New South Wales has been divided into a number of 'areas'. The term 'area' has been used since 1974 to describe a comprehensive health service that contains a hospital of two hundred and fifty to four hundred and fifty beds, nursing homes and related community based services, but excludes tertiary (specialist) hospitals. [10] In 1988, many of the area health services were amalgamated, substantially increasing the population in each area up to 640,000, in order to allow for greater re-deployment of resources by having most areas on boards responsible for several hospitals. The area health management model regarded 'area' as the most appropriate structure to meet the various criteria for comprehensive high quality service provision, cost efficiency, co-ordination and responsiveness to local communities, [11] and it also pulled together all hospital state-funded services and community health services under the same area structure. [10]

Two most important changes that affected senior health management in the New South Wales public health system were the introduction of the Senior Executive Service (SES) in 1989 and performance agreements introduced for SHEs in 1990. [2] The SES comprises public service department heads, senior executives of public service departments, heads of public authorities and senior executives and some senior positions in education. There are eight SES levels in NSW with level eight being the most senior.

The performance agreement for SHEs was the main document that defined the key accountabilities of the position. This was a key part of the performance management system that included regular feedback, coaching and review throughout the year. [12] As stated in the NSW Health Policy Review, effective performance management could increase motivation, foster productivity, improve communication, and encourage professional and managerial development. [12] For the first time, health plans and

budgets were directly linked to the performance of the organisation and its SHEs. The goals, key initiatives and targets for the SHEs for the next financial year were detailed in the agreements.

The reforms, the process of the reforms, and the instability they brought, have not only resulted in changes in SHE practices, but also in the competencies required for SHEs. Moreover, senior SHEs are believed to have carried extra responsibilities in implementing various changes, exercising a higher span of control and accountability, and being responsible for the effective and efficient running of healthcare organisations with high quality and flexibility. [3, 13-15] International studies show that while skills such as decision-making, planning and evaluation were seen as important in the 1980s, and are still ranked as important and relevant, leadership skills, skills in managing and leading change, and financial skills have been consistently more highly valued by senior healthcare managers in the 1990s and early 2000s. [16-19] Studies also suggest that healthcare reforms have resulted in changes to managers' career paths, the convergence of roles, new competencies and demands for higher educational qualifications for SHEs. [2] The number of SHEs in possession of postgraduate qualifications appears higher in studies from the 1990s and early 2000s than from the 1980s. [1] Furthermore, whilst it has been suggested in the past that background influences were seen as key in shaping career paths, [20] it is unclear whether, in the rapidly changing healthcare system of today, this is still the case.

Since the introduction of the SES in the NSW health system in 1989 and the performance agreements for SHEs in 1990, no study has been conducted to examine the possible effects the reforms have had on SHEs. This research follows two major studies of SHEs conducted in Australia in the middle and late 1980s: Rawson's study in 1985; [20] and the study by the Australian College of Health Service Executives (ACHSE), the Society of Health Administration Programs in Education (SHAPE) and the New Zealand Institute of Health Managers (NZIHM) in 1988. [21] This article builds on previously published aspects of a study that examined the experiences of those in SHE positions in the NSW health public system between 1990 and 1999. [1,2]

Methodology

A questionnaire was distributed, by mail, to those employed as SHEs in the NSW Department of Health and NSW Area Health Services between 1990 and 1999.

Definition of Senior Health Executives and sampling method

Although a number of studies on the SHE workforce have been conducted, the definition of what really differentiated levels of managers in the healthcare sectors and which criteria applied to the selection process have not been clearly stated. Very commonly, administrators in health authorities and hospital Chief Executive Officers (CEOs) were selected to represent the SHE Group, such as in studies conducted by SHAPE (1989) and Rawson (1986) in Australia, Dalston and Bishop (1985) and Guo (2003) in the USA, and Kanzanjian and Pagliccia (1993) in Canada. Rawson's study used salary as one of the selection criteria. [20] Using salary as the selection criteria for SHEs was not realistic for this study, given it covered a period of ten years, where the assumption could be made that salaries between the early part and later part of the study period could be very different.

After the introduction of the SES, the NSW Department of Health included the following positions as their SHE:

- Director General, Deputy Director General and Divisional Directors or General Managers from the Department of Health;
- CEOs of area health services;
- Senior staff who reported directly to the CEOs; and
- Hospital managers.

This definition brought the total number of SHE positions in New South Wales between 1990 and 1999 to 1,568. In order to improve the value of the study, data was collected from only those who reported directly to the Minister of Health and the Director General of Health providing a relatively homogenous sample in terms of position. This reduced the target population to 273 in the ten year period and meant that the current study did not include managers with a direct responsibility for management of hospitals.

The majority of targeted individuals stayed in their positions for more than one year, reducing the number of targeted SHEs to 79. After excluding those who were deceased or had only acted in the position for less than a year, the target population for the current study was further reduced to 71. Sixty out of the 71 potential respondents (80%) were contactable. They were either members of ACHSE, Australia or their contact details were publicly available.

Questionnaire design

The purpose of the structured survey questionnaire was to gather information on characteristics, employment status and background influences of the targeted SHEs, and to

identify the tasks on which the SHEs spent the majority of their working hours. The structured questionnaire was based on the questionnaires developed by Rawson's [20] and Harris et al's [15] studies. The aim was to gain information on:

- Sex;
- Age;
- Family situation;
- Background influences;
- Senior executive level;
- Senior executive position held at the NSW Department of Health;
- Tertiary education;
- Tenure in the senior executive position during the study period; and
- Major tasks undertaken.

In this study, senior executive level was used to identify the level of seniority of the respondents. Likert Scales 1 to 5, representing very dissatisfied to very satisfied, were applied to the forced-choice question regarding participants' satisfaction with different aspects of their work. For the question examining background influences, participants were asked to select the six background influences most relevant to their managerial career from a list of 18. They were also given the opportunity to specify other background influences that were important to them which were not listed.

As no study has been identified examining what SHEs or health managers really do, a new list of 15 key responsibilities/tasks for SHEs was compiled in consultation with two task lists from the Australian Bureau of Statistics, [22] for SHEs, and the NSW Department of Health (2004), [23] for CEOs, both of which covered the period of tenure of the participants in the study.

Data analysis

Data were manually entered into a database. Descriptive statistics and chi squares, where appropriate, were produced using SPSS® version 12.

Results

Response rate

In total, 31 out of 60 sent packages were returned, and 29 questionnaires were completed. The sending of reminders only generated one extra response (which was not a completed questionnaire).

This represents a response rate of 41% of the target population (n=71) or 48% of the accessible population (n=60). As postal surveys generally have response rates between 20% and 40%, [24] a response rate of 48% of the accessible population is seen as satisfactory.

Representativeness of respondents

Fourteen percent (14%) of the respondents to the questionnaire survey were female (n=4), while 86% of respondents were males (n=25). When comparing the gender distribution of the respondents to the accessible population (83% male), there were no statistically significant differences. CEOs from rural New South Wales appeared relatively under-represented among respondents (38%), but this represented no statistically significant difference to their representation in the accessible population (48%). Thus despite the comparatively low response rate, the sample was representative of the accessible population in terms of gender and location of employment.

Characteristics of respondents

Seventy nine percent (79%) of all respondents were no longer employed by the NSW Department of Health (n=23). Seventy nine percent (79%) of all respondents were under the age of 50 when they started their most senior position with NSW Health (n=23) and of these 65% were 35-44 years of age (n=15).

Seventy six percent (76%) of respondents stated that they were married (n=22), and a further 7% were in a de facto relationship (n=2) when they were in their most senior positions. Approximately half of the respondents (52%) had primary responsibility for a child or children of school age or below during their most senior position during the period under investigation (n=15).

All the respondents possessed tertiary qualification(s) ranging from certificate to doctorate. Among them, 31% held a bachelor's degree (n=9), whilst a further 52% had also obtained post-graduate qualifications (n=15). Among the tertiary qualifications, 72% were in administration or a related discipline (n=21) and 28% were in social science (n=8). Furthermore, 14% of respondents (n=4) were actively working toward a qualification whilst in their most senior position.

Nearly half of the respondents (48%, n=14) were classified under or equal to SES level 5. CEOs from rural New South Wales were more likely than Sydney CEOs to be classified at lower SES levels. Ninety one percent of rural CEOs (n=11) were classified as under or equal to SES level 5 whilst 10%

(n=3) of CEOs from metropolitan areas were classified as under or equal to SES level 5 (expected numbers of CEOs above SES level 5 were less than five in rural and metropolitan areas precluding calculation of a chi square).

Among all respondents, more than half (55%) stayed in their most senior position for less than or equal to three years (n=16) during the period under investigation. Twenty one percent of all respondents stayed in their most senior positions from three to five years (n=7) whilst 24% stayed more than five years (n=6). The average number of years the respondents had stayed in their positions was 3.1 years (2.8 years for women and 3.2 years for men).

Of the 15 tasks provided to survey participants for selection, two tasks were not selected by any of the respondents. These two tasks were:

- Ensured legislative and statutory compliance within the division or department; and
- Ensured the security and development of assets and resources.

The top four tasks most frequently selected by respondents were:

- Leadership to both staff and stakeholders was chosen by 90% of all respondents (n=26). In full, this was described as 'provided leadership to staff and stakeholders with clear vision and direction, including ensuring clear alignment between various levels of corporate goals, and led the implementation of management strategies'.
- Organisational planning was chosen by 72% of all respondents (n=21). In full, this was described as 'determined organisation objectives, policies and programs and set standards and targets'.
- External relations was chosen by 72% of all respondents (n=21). In full, this was described as 'maintained community and business relations, including consultative processes with the community, other health providers, area health professionals and stakeholders'.
- Monitoring and evaluation was chosen by 48% of all respondents (n=14). In full, this was described as 'appraised the activities of the department, division or area according to strategies and objectives, and monitored and evaluated performance'.

Background influences

Respondents were asked to rank the top six background influences in order of importance. The five most important background influences as selected by respondents were:

- Early experience and responsibility;
- Early leadership experience;
- Being in the right place at the right time;
- 'Stretching' by immediate superiors, and
- Formal education in administration at a university.

Discussion

Higher educational qualifications

The current study showed a high percentage of respondents with tertiary degrees (83%) ranging from bachelor to doctoral qualifications, of whom 38% reported possessing a master's degree or higher. This confirmed previous findings [25-27] that today's senior health managers possess much higher educational qualifications than those in the 1980s. The fifth background influence selected in the current study confirms the need for SHEs to advance their education.

Reasons for high turnover among participants

High turn-over and burnout among SHEs was commonly identified in the 1990s literature as a result of the pressure and impact of healthcare reforms. [28] In particular in the United Kingdom the merger of National Health Service Trusts has been found to initiate stress in managers due to increased workloads and general uncertainty. [29] The current study confirmed the issue of high turnover among SHEs, finding an average tenure of three years among the sample. High turnover among the study population was also reflected by the high percentage (79%) having left the NSW Department of Health.

The current study suggests that turnover among SHEs is an important issue to be addressed, especially during the implementation of changes within the system or the organisation. The following strategies can be developed to minimise the severity of turnover:

1. reduce the pace of the reform process to sustain the outcome of changes;
2. provide ongoing professional development programs to SHEs to develop advanced skills in fulfilling the new managerial demands; and
3. provide leadership programs to SHEs to equip them in effectively managing and leading the reform process.

Differences among CEOs from rural and metropolitan areas

The study indicated that CEOs from rural NSW were classified at a lower SES level, with 91% of them (n=10) classified as under or equal to SES level 5 whereas only 10% of metropolitan CEOs were classified as under or equal to

SES level 5. According to SES Guidelines developed by the NSW Premier's Department (2005), [30] the level of a position is based on the work value of the position, not the skills or experience of the occupant of the position. Therefore it may be assumed that CEO positions in rural areas carry fewer responsibilities than those in Sydney metropolitan areas. However, documents that indicate the differing requirements and expectations for CEOs from rural and metropolitan areas have not been found, and there is no literature or other studies explaining why this difference may exist. Further investigation may be advisable to explore the implications of such differences.

Background influences

Background influences for becoming a SHE identified by this study are different from those identified by Rawson's study. [20] Both Rawson and this study found that the top two background influences for becoming a senior healthcare manager are: early experience and responsibility, and early leadership experience. However, the number three and four background influences between two studies are different. Being in the right place at the right time, and 'stretching' by immediate superiors were selected by the current study, replacing an overall sense of mission in life, and family support identified in Rawson's study. Changes in the number three and four background influences can be seen as a reflection of the unstable and continuously changing healthcare system. Senior health executives were promoted to the most senior positions at the time of the healthcare restructuring which may have provided them with unexpected opportunities. At the same time, the career path of clinicians may have been changed when they were unexpectedly offered senior management roles. [31] These may be examples of being in the right place at the right time and 'stretching' by immediate superiors.

Major roles and responsibilities

This study identified four main tasks for SHEs to perform: leadership for both staff and stakeholders; organisational planning; external relations; and monitoring and evaluation. 'Monitoring and evaluation' is a role that has not been mentioned in previous studies. This may reflect the changes in SHEs roles in recent years.

Further exploration of what competencies are required for SHEs to fulfil the four major roles is necessary to guide the development of appropriate training and professional development programs for current and future SHEs to more effectively prepare them for their demanding and challenging managerial roles.

Limitations of the study

The study did not include hospital CEOs. Given the significant changes implemented to public hospitals in New South Wales such as abolition of hospital boards, changes in funding arrangements, tightened budgets and control, and financial pressure etc, impacts on hospital CEOs may be profound. The changes may lead to changes in CEO managerial practice. The findings of the current study do not represent this group.

Although the response rate was within the normal range for postal surveys, [24] the number of survey participants is small. However, comparison with those figures that are available (gender and location of employment) showed that the sample was representative of the target population.

Conclusion

Since the introduction of the SES in 1989, no study has attempted to examine the changing roles and responsibilities of SHEs, including their characteristics, employment status, background influences and the major tasks they undertake. This study has found a number of phenomena similar to those found in other studies carried out worldwide in the 1990s. These common phenomena include senior healthcare managers generally possessing higher qualifications in the 1990s than in the 1980s and high turnover among SHE positions due to a number of significant factors such as an unstable healthcare system, lack of support and supervision, and job insecurity.

The study also found that two of the major background influences identified are different from those identified by Rawson. [20] These two newly emerging important background influences – 'being in the right place at the right time', and 'stretching' by immediate superiors – may be a reflection of the unstable and fast pace of restructuring healthcare systems, which may have contributed to the high turnover among the SHE positions, but on the other hand created opportunities for clinicians or middle level managers to be promoted to top-level managerial roles.

The main tasks to be undertaken by senior health executives between 1990 and 1999 were also identified. Among them, monitoring and evaluation of services and performance has not been seen as an important component in the roles of senior healthcare managers in the past. This most significant finding suggests the need for further investigation and consideration when reviewing the current educational programs that prepare senior healthcare managers for top-level managerial roles.

Competing interests

The authors declare that they have no competing interests.

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References

- Liang Z, Short S, Brown C. Senior health managers in the new era: changing roles and competencies in the 1990s and early 21st century. *The J Health Adm Educ.* 2006;23(3):281-301.
- Liang Z, Short S, Lawrence B. Healthcare reform in New South Wales 1986-1999: using the literature to predict the impact on senior health executives. *Aust Health Rev.* 2005;29(3):285-91.
- Rathwell T, Persaud D. Running to stand still: change and management in Canadian healthcare. *Healthc Manage Forum.* 2003;15(3):10-7.
- Brown K, Waterhouse J, Flynn C. Change management practices: is a hybrid model a better alternative for public sector agencies? *International Journal of Public Sector Management.* 2003;16(3):230-41.
- Maor M. The paradox of managerialism. *Public Administration Review.* 1999;59(1):5-18.
- Higgins I. Benchmarking in healthcare: a review of literature. *Aust Health Rev.* 1997;20(4):60-9.
- Gauld R. The impact on officials of public sector restructuring: the case of the New Zealand health funding authority. *International Journal of Public Sector Management.* 2003;16(4/5):303-29.
- Officer CH. *The health of the people of New South Wales.* Sydney: New South Wales Department of Health; 2004.
- Crichton A. *Slowly taking control? Australian governments and healthcare provisions 1788-1988.* Sydney: Allen & Unwin; 1990.
- Lawson J, Evans A. The successful development of decentralised health service management: an evaluation of area health services in New South Wales. *Aust Health Rev.* 1992;15(3):237-47.
- New South Wales Department of Health. *Annual Report 84/85.* Sydney: 1985.
- New South Wales Department of Health. *Policy Directive: SES performance management system – NSW Health.* Sydney: 2005.
- Kirkman-Life B. Management without frontiers: health system convergence leads to healthcare management convergence. *Front Health Serv Manage.* 1994;11(1):3-48.
- Southon G. Health service structure, management and professional practice: beyond clinical management. *Aust Health Rev.* 1996;19(1):2-16.
- Harris M, Maddern J, Pegg S, Associates. *The changing roles and careers of Australian and New Zealand health service managers.* Sydney: ACHSE; 1998.

16. Guo K. An assessment tool for developing healthcare managerial skills and roles. *J Health Manage.* 2003;48(6):367-76.
17. Harris M, Beakley M. Competencies required of health service managers in the 1990s. *Aust Health Rev.* 1991;14(4):363-79.
18. Wenzel F, Grady R, Freedman T. Competencies for health management practice: A practitioner's perspective. *J Health Adm Educ.* 1995;13(4):611-30.
19. New South Wales Department of Health. Annual Report 03/04. Sydney: New South Wales Department of Health; 2004.
20. Rawson G. Senior health service managers: characteristics and educational needs. *Australian Studies in Health Services Administration.* University of New South Wales 1986;57.
21. SHAPE. A report of the professional development needs of senior Australian health executives in response to challenges in the health system. Sydney: ACHSE; 1989.
22. Australian Bureau of Statistics: Australian Standard Classification of Occupations (ASCO) Second Edition: Structure & Definitions 1292 Health Services Managers, Canberra; 2002. Available at www.abs.gov.au/ausstats/abs@.nsf/
23. NSW Department of Health: Health Executive Service Performance Management System: Chief Executive Officer Model Agreement, Sydney; 2004.
24. Nachmias D, Nachmias C. *Research Methods in the Social Sciences.* New York: St Martin's Press; 1981.
25. Dalston J, Bishop P. Health care/Healthcare executive education and training. *J Health Adm Edu.* 1985;13(3):437-52.
26. Eynde D, Tucker S. Personality patterns of healthcare and industry CEOs: similarities and differences. *Health Care Manage Rev.* 1996; 21(2):87-95.
27. Tomiak M, Gentleman J, Jette M. Health and gender differences between middle and senior managers in the Canadian public service. *Soc Sci Med.* 1997;45(10):1589-96.
28. Waldman J, Kelly F, Arora S, Smith HL. The shocking cost of turnover in Health Care Manage Rev. 2004;29(1):2-7.
29. Fulop N, Protosaltis G, Hutchings A, King A, Allen P, Normand C, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *Br Med J.* 2002;325: 246-52.
30. New South Wales Premier's Department. SES Guidelines: a manual of SES Administration. Sydney: Public Employment Office; 2005.
31. Tobin M. Transition from clinician to manager: a case study. *Aust Health Rev.* 1993;16(1):51-9.



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