National Guidelines for the Promotion of Healthy Working Environments
A Framework for the Health and Disability Support Sector
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The Health Workforce Advisory Committee (HWAC) is an independent committee appointed by, and reporting directly to, the New Zealand Minister of Health. It provides the Minister of Health with strategic advice on the health and disability workforce.
Executive Summary

In 2003, The Health Workforce Advisory Committee (HWAC, the Committee) identified progressing the development of healthy workplace environments as a key priority for New Zealand’s health and disability support sector.

Developing such environments will enhance our ability to recruit and retain appropriate staff in a competitive global environment, have financial benefits for health service providers and, perhaps most importantly, have a positive impact on the health outcomes of health and disability support service users. This advice to the Minister of Health provides a set of principles to use as guidelines for developing healthy workplace environments in the sector.

The health and disability support sector is highly diverse, including a wide range of practitioners, settings, models of ownership and service delivery, and approaches to providing care and support. For this reason, the Committee has not developed a ‘one-size-fits-all blueprint’ for the development of healthy working environments. Instead, the principles set down the six key aspects of a healthy workplace environment, and the general characteristics that constitute ‘healthy’ practice in each of these areas.

The principles identified by the Committee are:

1. Organisational Culture
2. Leadership and Decision-Making
3. Change Management
4. Information and Knowledge-Sharing
5. Career Development

Decision-makers in the health and disability support sector can use these characteristics as reference points on which to base strategies that will reflect the detail of their own particular work setting. The Committee has also highlighted several important issues that must be borne in mind by those instituting healthy working environments. These are:

- change management processes
- management choices
- the type of leadership practised
- the extent to which clinical governance is common practice
- recognising and managing professional diversity
- effective monitoring arrangements.

‘Developing such environments ... will have a positive impact on the health outcomes of health and disability support service users.’
‘ENHANCING OUR ABILITY TO RECRUIT AND RETAIN APPROPRIATE STAFF IN A COMPETITIVE GLOBAL ENVIRONMENT...’
Recommendations

The Health Workforce Advisory Committee recommends that the Minister of Health:

1. explicitly promote the importance of developing healthy working environments in the health and disability support sector. This could be achieved by:
   • inclusion of ‘a workforce that practises in healthy working environments’ as an explicit goal or objective in any revisions of the New Zealand Health Strategy
   • directing the Ministry of Health to explicitly address the working environments of the health and disability support workforce in any future strategies it develops

2. accept the principles identified by the Committee as a basis for developing healthy working environments in the health and disability support sector

3. communicate an expectation to the publicly funded health and disability support sector that it makes the development of healthy working environments a priority, and that the Minister strongly endorses the development of healthy working environments in the privately funded sector

4. direct the Ministry of Health to explore how it can best monitor and support the development of healthy working environments.

Principles for a Healthy Working Environment

**ORGANISATIONAL CULTURE (NORMS, VALUES, BELIEFS AND BEHAVIOURS)**

**A healthy work environment:**
- will have the health and wellbeing of the person as its primary objective
- reflects a culture that values employees and promotes trust between staff
- demonstrates people working collaboratively as teams and forming constructive relationships to achieve shared objectives
- enables effective and open multi-level communication channels
- encourages and supports change and innovation
- fosters creativity
- promotes continuous learning
- has a risk management approach that supports staff and is not simply risk aversion
- recognises and adapts to changing work–life balance
- reflects a culturally aware environment that is supportive of, and responsive to, the increasing diversity of the workforce.
LEADERSHIP AND DECISION-MAKING

- Governance structures and systems support staff involvement in decision-making, implementation and the review of initiative success in their area of expertise.
- Participatory management is commonplace with staff involved in decision-making in their area of expertise and influence.
- Partnerships are established between the management and clinical cultures.
- Clinical leadership and shared clinical governance are promoted.
- Professional autonomy and accountability is promoted and valued.
- Leadership is continually developed and supported at all levels of the organisation.
- Leadership focuses on people, their potential, their impact, and what makes them function optimally.
- Effective feedback systems are developed.

CHANGE MANAGEMENT

- Change is managed as a normal and ongoing characteristic of the workplace, and good processes and principles are evident.
- Organisations engage in change management processes that help build and maintain organisational trust.
- Change has a rationale, is managed through action plans, and is monitored to enable future learning.
- Frontline staff are involved in the definition of problems and the design of solutions.
- Change is preceded by robust consultation processes with those who will be affected.
- Opinion is sought and considered throughout the process from all who are involved in, or will be affected by, the change.
- Effective evaluation mechanisms are put in place and used.
**INFORMATION AND KNOWLEDGE-SHARING**

- Excellent information is collected to assist organisations to understand their workplace and staffing needs.
- Demographic information is collected about staff and used to customise organisational design.
- Evidence about working environment success is collected and shared with the staff and, where appropriate, the sector as a whole.
- Comprehensive information is regularly collected about staff satisfaction with aspects of their environment, and is used to inform future decisions and actions to promote a healthier working environment.
- Organisations co-operate and share information with each other to help gain a national picture of future trends.
- Knowledge and solutions are shared.

**CAREER DEVELOPMENT**

- Staff are developed throughout their employment by high-quality systems.
- Individuals are oriented to the work environment by their team.
- Career development opportunities are readily available.
- Research is recognised as a legitimate work activity where appropriate.
- Staff receive feedback on performance and are actively involved in their performance development plan.
- Training and continuing education/learning is conducted on-the-job and through professional agencies.

**EMPLOYEE RECOGNITION**

- Staff are expected to perform well and are recognised appropriately.
- Remuneration is fair.
- Workloads and skill-mixes are optimally designed.
- Casual labour usage is minimal.
- There is flexibility in job design and work arrangements.
- Clinicians take responsibility for making timely decisions based on expert judgement.
- Excessive levels of stress are recognised as an occupational hazard and actively managed and monitored, and effective processes are provided to support affected staff.
- Employee assistance is provided where appropriate.
‘...COMMENDED TO CHALLENGING THE HEALTH AND DISABILITY SECTOR TO CREATE IDEAL WORKING ENVIRONMENTS THAT ARE NOTABLE FOR POSITIVE PEOPLE, HIGH PRODUCTIVITY, LOW STAFF TURNOVER AND EFFICIENT AND EFFECTIVE PROCESSES.’
Introduction

The Health Workforce Advisory Committee (HWAC, the Committee) has always been a firm proponent of healthy working environments. In its initial work, the Committee found that the working environment of New Zealand’s health and disability support sector was characterised by:

- a degraded infrastructure to support health workforce planning and development
- an inadequate information base in most respects
- poor communication and co-operation between stakeholders
- narrow, siloed thinking in work settings and occupational areas
- unhealthy and sometimes dysfunctional work environments
- little trust in political, managerial and health professional leadership
- a fragmented, confused and, in places, demoralised and angry workforce protective of parochial interests and cynical and fearful of further change (HWAC 2003).

In recent years, organisations such as HWAC, the Ministry of Health, individual District Health Boards (DHBs), non-government organisations (NGOs), professional bodies and others have put considerable effort into redressing this situation. As part of this, the Committee’s Framing Future Directions (2002) and Future Directions (2003) documents identified progressing the development of healthy working environments as a key priority for the sector.

One of the main reasons for this is the significant change facing New Zealand’s health and disability support sector. In this environment, ensuring that workplaces are ‘healthy’ will be critical to retaining an appropriate and sustainable supply of health and disability support workers.

HWAC is committed to challenging the health and disability sector to create ideal working environments that are notable for positive people, high productivity, low staff turnover and efficient and effective processes.

‘ensuring that work places are “healthy” will be critical to retaining ... workers’

These environments benefit the health provider organisation, the organisation’s workforce, and the health outcomes of the service users.

The Committee has developed this advice to the Minister of Health in order to meet this objective. This report presents a set of national guiding principles that provide a framework to promote healthy workplace environments throughout the health and disability support sector, and the Committee recommends that the Minister widely promote these principles. These principles draw on the initial work of the Committee, internal work on current best practice and research in the area, and commentary from a Technical Advisory Group comprising stakeholders from the sector.

These principles have been phrased in terms of desired outcomes – the types of characteristics that are present in a healthy working environment. The Committee intends them to be used by those in the health and disability support sector as a reference point on which to base initiatives and strategies to successfully influence the future workplace environment. These principles will also assist the sector to develop and respond to new ways of delivering health services, such as at the primary/secondary care interface.

The Committee would like to thank all those who have participated in the development of this advice. In particular, the Committee extends its sincere thanks to the members of the Technical Advisory Group for their advice and input. The Committee would also like to specifically recognise the invaluable contribution of Professor Rod Perkins for his advice on leadership and governance issues.

1 A list of the Technical Advisory Group members can be found in Appendix Two.
‘THE VISION OF A HEALTHY WORKING ENVIRONMENT UNDERLYING THIS ADVICE IS ONE IN WHICH PEOPLE WORK IN A POSITIVE ENVIRONMENT IN WHICH THEY ARE VALUED AND THAT SUPPORTS THEM TO WORK IN AN EFFECTIVE MANNER.’
1 Background

1.1 WHAT ARE HEALTHY WORKING ENVIRONMENTS?

There is no single, universally accepted definition of healthy working environments (HWE). Some versions of the concept concentrate on the ‘healthy’ side and are primarily concerned with issues such as mental and physical occupational health and safety, or the use of the workplace as a site for generally improving the health of the workforce.

Others emphasise the ‘working environments’ aspect, and focus on developing an environment that encourages a positive and effective workforce. Some, for example, have actually argued that it is more appropriate to talk about ‘healthy organisations’ than ‘workplaces’.

These different approaches stem largely from differing emphasis on three general elements or domains within the overall healthy working environments concept (Burton 2004):

- Physical environment – traditional occupational health and safety concerns, covering issues such as exposure to hazardous materials, ergonomic hazards, operation of machinery etc.
- Health practices – the personal activities of individuals in the workplace that impact on their health, such as smoking, sedentary working styles etc.
- Psychosocial environment – non-physical aspects of the working environment such as styles of communication, management systems, work–life balance etc.

‘people work in a positive environment in which they are valued and that supports them to work in an effective manner’

This document focuses mainly on the third of these elements. The vision of a healthy working environment underlying this advice is one in which people work in a positive environment in which they are valued and that supports them to work in an effective manner. This approach has the advantage of incorporating the health of individual workers into the wider context of ensuring that New Zealand has a health and disability support sector that works efficiently and effectively to promote the wellbeing of individuals and communities. Developing healthy workplaces is therefore not just about...
ensuring the existence of healthy workforces, but developing well-functioning organisations as well. As Lowe (2004b) points out:

‘… the foundations of a healthy work environment are good communication, a positive relationship with one’s supervisor, friendly and helpful co-workers and receiving recognition. Both employees and employers benefit from these “healthy” relationships through higher job satisfaction and commitment, reduced turnover and less absenteeism.’

In this context, the general attributes of healthy workplaces have been defined as including:

- a strong vision
- people-centred values
- effective teamwork
- customer service or product quality
- information-based management decisions
- genuine employee involvement in decision-making
- open communication
- support for individual learning and development
- emphasis on innovation and creativity
- support for work-life balance (Lowe 2004a).

There is therefore significant overlap between the Committee’s vision of healthy workplace environments and the concept of high-performing organisations. High-performance practices have been described as an:

‘…organisational architecture that brings together work, people, technology, and information in a manner that optimises the congruence or “fit” among them in order to produce high performance in terms of the effective response to customer requirements and other environmental demands and opportunities’ (Nadler et al 1992).

Introducing such practices has been found to have clear benefits in terms of enhancing both the retention of high-quality staff and improving the overall performance of the workforce (Huselid and Becker 1995).

As with healthy workplaces, the concept of ‘high performance practices’ is something of an umbrella term covering a variety of activities. The diversity of possible working arrangements means that there is no single group of specific practices that can be considered high performance in all settings. However, when various models are compared, the following key themes emerge (International Labour Organization 2002):

- employee autonomy and involvement in decision-making
- employee performance support
- recognition of skills and contribution
- information and knowledge sharing.

Appendix One of this report compares several different models of such practices against these dimensions.

Implementing such practices in bundles is a key determinant in the success or failure of high-performance practices. It has been found that it is ‘the combination of practices in a bundle, rather than individual practices, that shapes the pattern of interactions between and among managers and employees’ (MacDuffie 1995). In other words, the key themes cannot be seen as a ‘pick list’ of separate practices.

One important point to note is that the development of healthy workplaces is the responsibility of all those in the health and disability support sector, and not the sole responsibility of the employing organisation or individual. A cornerstone of the HWE philosophy is that of collaboration, and it is important to recognise that this places obligations on employees as well as those who employ them. Some strategies – such as the involvement of staff in workplace decision-making – must be initiated and driven by employers. However, when such measures are put in place, health and support workers must approach such structures fairly and with a genuine commitment to making them work.

Furthermore, there are aspects of healthy workplaces where responsibility for
implementation must lie primarily with the workforce itself. For example, while an employer can create an environment that promotes collaborative and equitable relationships between staff, the actual creation of such relationships is reliant on the actions of staff members themselves. The successful development of a healthy working environment is therefore dependent on a commitment that is shared by both employers and employees.

1.2 THE NEED FOR ACTION

The Committee believes that actively promoting healthy working environments is imperative if we are to ensure the effective and sustainable provision of health and support services.

The need to address these issues is particularly pressing given that the health and disability support sector is experiencing a period of significant and widespread change. Some of this stems from wider social phenomena, such as changing demographics, the spread of Information Technology, or increasing social and economic globalisation. Other drivers are more specific to the sector, such as changes in practice and interventions, policy expectations or the structures that deliver health and support services.

These issues have been well-explored in many places. Furthermore, many specific parts of the sector – such as the aged care sector, NGOs, and the unregulated workforce – are experiencing their own distinct issues. There are, however, several overarching and interrelated trends, challenges and issues for the sector as a whole that highlight the need for action. These include:

**The ageing population**

New Zealand’s ageing population will change both the level and type of demand for health and support services, and affect the health and disability support workforce itself. In particular, as the workforce becomes older there is likely to be an increase in the numbers of those retiring or desiring alternative arrangements involving greater work–life balance, such as less shift work and more part-time work.

**Increasing diversity**

New Zealand is becoming a more ethnically diverse society. Changes in both migration and birth rates means that our future society will be far less dominated by those of European descent. This will give even more importance to the ability to practice in a culturally safe manner, and to the development of a workforce and models of service delivery appropriate to a diverse range of cultural backgrounds.

**Technological change**

The growth of new technologies creates both opportunities and problems for the sector, whether part of a wider trend such as the growth of Information and Communication Technologies (ICT) or specifically in the health and disability sector through the development of new interventions and approaches to care.

On the one hand, new and improved technologies have the potential to enhance care and support through better access to information or more effective and efficient treatments and support systems. Conversely, developing the skills and infrastructure necessary to use these advancements can result in pressure on the workforce. This can particularly be the case given the increasingly informed nature of consumers and their desire to more actively participate in their health care.

**Changing approaches**

Strategies and plans promulgated by the government, contain explicit and implicit expectations about how health and support services should be delivered. This is the case with both high-level strategies such as the New Zealand Health Strategy and the New Zealand Disability Strategy, and more focused strategies such as
the Primary Health Care Strategy or Health of Older People Strategy. Most notably, there now exists a strong vision of more multidisciplinary, flexible and person-centred services based around principles of partnership and collaboration between the community, service delivery organisations and the workforce.

**Structural and professional changes**

Although the dramatic reforms of the sector that characterised the 1990s have largely come to an end, the health and disability support sector is still dealing with the effects of profound change in the organisation of service delivery and the structure of health professions. District Health Boards are still comparatively new, and the Primary Health Organisation (PHO) model of primary health care delivery is even more recent. As well as structural change, there have been changes within the regulated health professions, originating both externally – through, for example, the introduction of the Health Practitioners Competence Assurance Act 2003 – and internally, through practitioners’ desire to explore new roles and modes of practice.

**Changing skill mix**

Many groups of health and disability support workers are grappling with changes in the skills required to carry out their expected activities. The factors responsible for these skill mix shifts are complex and interrelated. They include many of the above trends, such as ongoing technological advances, changing community expectations, legislative and regulatory change and changing professional aspirations, and other factors such as increasing sub-specialisation in disciplines.

There will inevitably be tensions between different groups of workers as each continues to grapple with these issues. However, the health and support workers of the future will clearly need to be equipped to work in multidisciplinary teams across a number of settings, including home-based, community, clinic and hospital environments.

**Changing expectations of the workplace**

There is some evidence to suggest that employee expectations of the workplace are changing. As Clements et al (2002) write:

‘Employees are increasingly wanting time for family and activities other than paid work. Our societies are becoming more diverse with the many different cultural patterns influencing people’s wants and needs. Many people do not wish to or cannot work the standard 9-5 working day, yet have many of the skills employers require.’

These changing expectations are most evident in increasing discussion about, and desire for, appropriate work-life balance. Furthermore, until recently the primary community for people outside of their family may well have been a church group, service or sports club or voluntary society. Now, however, increasing work hours, declining church and civic membership and reduced volunteerism means that for large numbers of people their workplaces may be their primary community apart from home. Current debates over work/life balance are as much about the opportunity for employees to express and see their values acknowledged and nurtured as purely about hours of work.

**Increasing globalisation**

One of the most prominent phenomena of the late twentieth and early twenty-first centuries has been the increasingly global nature of society, culture and economies. For the health and disability support sector, globalisation in its own right (rather than, for example, its contribution to demographic change through migration) has two main impacts. The first of these is on the nature of the conditions the sector must address. For example,
increased international mobility makes it easier for contagious disease to spread.

Perhaps more important, however, is the increasingly global nature of the health workforce itself. The world market for health and support professionals is now firmly an international one, and countries are increasingly forced to compete with each other to attract and maintain these workers. This is particularly important given that both New Zealand and the world as a whole are currently experiencing a significant shortage of such practitioners.\(^5\)

These and other factors mean that the development of healthy working environments is vital. These trends and pressures indicate that the health and disability support sector is both currently experiencing the effects of significant change, and that it will need to continue to adapt to address new expectations and requirements. It is therefore critical that working environments in the sector are sufficiently robust and positive to withstand the inevitable pressures that are affecting them now and will affect it in the future.

Of particular importance is the issue of recruitment and retention. Two of the factors noted above, specifically globalisation and the ageing population, point to the need for New Zealand to seriously consider how it can recruit and retain a sufficient and appropriate mix of health and support workers.

Our health and disability support workforce has a generally older profile than the labour market as a whole (Cornwall and Davey 2004; HWAC 2005) and is continuing to age. The point noted earlier that older workers are more likely to be seeking alternative arrangements such as part-time work, and be less enthusiastic about such forms as shift-work will therefore impact particularly strongly on the sector. The NZIER (2004) has estimated that there will soon be severe workforce shortages stemming from the ageing workforce unless New Zealand significantly enhances its ability to retain and recruit staff.

Similarly, the increasingly global market for health professionals and the existence of an international shortage of such workers gives the workforce far more options in terms of seeking out new employers when their existing ones prove unsatisfactory. The comparatively high level of overseas-trained professionals in our sector\(^6\) also makes maintenance of our workforce reliant on continuing to be seen internationally as an attractive place in which to work. Given that New Zealand will always find it difficult to compete with other countries on the basis of salaries and resources, we must cultivate other incentives to join and remain in our country’s health and support workforce.

Developing working environments that recognise and address these pressures is therefore vital to maintaining a well-functioning health and disability support system. Ensuring that working environments and arrangements take account of issues such as the desire for work–life balance, the stresses created by institutional and professional change and the pressures of changing approaches to care and support must be a critical element of any strategy for maintaining a high quality and well-functioning health and disability support sector.

### 1.3 The Benefits of Healthy Working Environments

There are several reasons to implement healthy working environments. The first and most fundamental of these is a simple belief about the nature of the workplace. The Committee believes that all workplaces should be positive and enjoyable environments in which to work that do not impact negatively on people’s physical, social, cultural and mental wellbeing.

Beyond this basic starting point, however, implementing healthy workplace policies will also have material advantages. The first of these are likely financial benefits. As Yasbek (2004) points out in relation to promoting work–life balance, the direct and indirect costs of instituting HWE strategies are usually counterbalanced by both increased productivity and significant cost savings. For example, the cost of stress-
related absences, an often-cited measure of ‘unhealthy’ work environments, has been estimated in Canada to cost CAN$3.5 billion per year (Statistics Canada, cited in Lowe 2004b). Analyses of implementing health promotion activities have estimated cost–benefit ratios of 1:3 to 1:8 (Lowe 2002).

Implementing healthy workplace environments can have positive outcomes not only for the workforce, but for the financial status of the organisation itself (see Figure 1). This will be of particular benefit given the financial constraints experienced by many of New Zealand’s health and disability support providers.

Implementing HWE initiatives can also have significant benefits for quality of care. For example, there appears to be strong evidence that a workforce’s level of satisfaction with their working environment impacts on the quality of their clinical practice. a 2003 systematic evidence review found clear evidence for the general impact of working environments on the provision of health care (Hickam et al 2003). The Institute of Medicine (2001) in the United States has identified the lack of appropriate systems to support practitioners as a key reason for safety and quality issues in parts of the American health system.

Not only is an unhealthy working environment therefore a problem for practitioners on a personal level, but working in an unhealthy environment can directly or indirectly impact on the quality of their work. As Burton (2004) indicates:

“Workers experiencing psychosocial hazards may:
- sleep badly
- over-medicate themselves
- drink excessively
- feel depressed
- feel anxious, jittery and nervous
- feel angry and reckless (often due to a sense of unfairness or injustice).”

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7 HWAC 2002 (adapted from Norman 1999; Becker and Huselid 1998).
8 See, for example, Dwore et al 1997; Sherer 1997; Coile 2001; Jenkins and Wong 2001; Valentine 2001; Aiken et al 2002.
When people engage in these behaviours or fall prey to these emotional states, they are more likely to:
- become momentarily distracted
- make dangerous errors in judgement
- put their bodies under stress, increasing the potential for strains and sprains
- fail in normal activities that require hand-eye or foot-eye co-ordination.

Of particular importance in this regard is the existence of a feedback relationship in which positive working environments lead to behaviours that promote performance, which in turn leads to a more positive environment.

Conversely, unhealthy workplaces often experience a negative feedback effect in which the work environment has a detrimental impact on staff morale and motivation, leading to difficulties in attracting and retaining high quality staff and reduced quality of care. Unless an organisation addresses underlying issues, the responses it makes to this situation can amplify the already negative environment and aggravate these detrimental outcomes. This is illustrated in Figure 2 above.

In the health sector, the strongest evidence for benefits of healthy working environments is that associated with the Magnet Hospital concept. The Magnet model grew out of research in the early 1990s by the American Nurses Credentialling Centre (ANCC) aimed at identifying successful practices for enhancing the recruitment and retention of nurses. Subsequent evaluation has identified many positive outcomes from such institutions, including:
- For patients:
  - lower mortality rates
  - shorter lengths of stay

9 It should be noted that the review itself admitted (pp.21–22) that its method of analysis was not well suited to adequately assessing much of the available literature, and that it therefore may have actually underestimated the level of evidence for the impact of specific working environments.

10 The characteristics of Magnet Hospitals are described in Appendix One’s comparison of high-performance practice models.

- increased patient satisfaction
- lower utilisation of ICU days.

• For nurses:
  - higher nurse ratings of quality of care
  - lower incidence of needlestick injury
  - lower rates of burnout
  - better collaboration with other healthcare professionals.

• For organisations:
  - higher JCAHO scores
  - lower staff vacancy and turnover rates.

The specific practices and outcomes in the Magnet model are clearly most relevant for hospital settings. However, in more general terms they demonstrate how the development of healthy working environments can have positive impacts for the public, the workforce, and health and disability support providers.

The final core benefit from implementing healthy workplaces lies in the area of recruitment and retention. The evidence review noted earlier (Hickam et al 2003) found a firm positive link between the experience of staff and higher quality of care. This points to the ability to retain experienced workers as being a key way to ensure the provision of a high standard of health and support services.

Providing a healthy working environment is one way in which organisations can address this issue. The Magnet evaluations noted above, for example, found that nursing turnover and burnout were significantly reduced at such hospitals. Similarly, a 2001 report for the Ontario Hospital Association concluded:

‘The key trends in retention research include several key factors starting with the basics of recruitment and compensation. However, for staff to remain with an organisation, the work itself must be seen to be challenging, with opportunities to participate in decision-making and the ability to influence the nature of the work and the organisation. Work–life balance must be supported. Career growth and opportunities need to be present. Opportunity for development is described as advancement, vertical or lateral movement, paid training and on-going learning opportunities.’

(PriceWaterhouseCoopers 2001)

The practices described in the Ontario report are all key components of healthy workplace strategies, suggesting a strong link between implementing such practices and improved ability to retain staff.

Along the same lines, Coile (2001) notes that although competitive wages are important in attracting staff, ‘philosophy and organisational culture are much more significant’, as is the practitioner–patient ratio, support for the practitioner’s role, a decentralised management system, and delegated responsibility for decision-making relating to patient care. Coile therefore suggests that in the modern environment, health organisations ‘need innovative, culture-based approaches to recruit and retain staff’.

This aspect is particularly important given the previously noted point that New Zealand must now compete with other countries for health workers in the context of both a national and a global workforce shortage. Although debate exists over how best to resolve this, the Committee believes that all stakeholders can agree that this situation requires New Zealand to possess working environments that are conducive to recruiting potential staff and retaining the workforce we do have.

**Summary: The Benefits of Introducing Healthy Working Environments**

- Improved work–life quality for health practitioners through:
  - greater staff morale
  - greater job satisfaction
  - improved service delivery quality.

- An appropriately designed work environment.

- Improved organisational performance and sustainability through:
  - reduced staff turnover and absenteeism

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12 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provides quality assurance standards and evaluations for over 15,000 providers of healthcare across the United States.
- improvements in health care quality
- greater trust and commitment within the organisation
- better communication within the organisation.

- Improved recruitment and retention of a quality workforce.
- Ultimately, better health outcomes delivered by a stable, satisfied, motivated and empowered workforce that provides healthcare to the full extent of its capabilities.

For all these reasons, ensuring that New Zealand’s health and disability support workers practise in a positive work environment is vital to realising the goals set out in the New Zealand Health Strategy and the New Zealand Disability Strategy. As the Joint Learning Initiative’s report on the global health workforce notes:

‘Health workers are the linchpin, the keystone, the pivot of all efforts to overcome all health crises … Only when high-level initiatives, finance, and technologies are matched by an investment in people will the formula for better health for all people be credible and effective’ (Joint Learning Initiative 2004).

The Committee believes that the development of healthy working environments must be seen as a key goal for New Zealand’s health and disability support sector. Individual workplaces and organisations must take ultimate responsibility for developing such environments. However, the Committee also believes that there is a role for central government to play in promoting the concept of healthy working environments, and ensuring their creation is on the agenda of the health and disability support sector.

A starting point for this promotion could be the inclusion of healthy working environments in strategic documents produced under the auspices of the Minister and Ministry of Health. Documents such as the New Zealand Health Strategy and the Primary Health Care Strategy set down explicit and implicit expectations of the health and support sector. Including discussion of working environments in such publications would thus ensure that the concept becomes embedded in the sector.

The New Zealand Health Strategy already includes the general Objective of ‘develop and implement healthy workplace programmes’, associated with its Goal Five: ‘Healthy communities, families and individuals’. The Committee believes, however, that there is scope to explicitly recognise the importance of such environments specifically for the health and support workforce.

This could be achieved by adding an appropriate Objective associated with either Goal Five (to align with the existing general Objective) or Goal Ten: ‘Accessible and appropriate health care services’. This second possibility is based on the Committee’s belief that providing such services depends strongly on the creation of healthy working environments.

Alternatively, a new population health Goal could be developed specifically around the development of healthy working environments. The Minister may also wish to work with the Minister for Disability Issues to consider how a relevant Objective relating to the disability support workforce could be included in the New Zealand Disability Strategy.

**RECOMMENDATION ONE**

The Health Workforce Advisory Committee recommends that the Minister of Health explicitly promote the importance of developing healthy working environments in the health and disability support sector. This could be achieved by:

- inclusion of ‘a workforce that practices in healthy working environments’ as an explicit goal or objective in any revisions of the New Zealand Health Strategy
- directing the Ministry of Health to explicitly address the working environments of the health and disability support workforce in any future strategies it develops.
Employment settings can range from large, physically static institutions such as hospitals, to a dispersed but linked series of small practices such as a primary health organisation, through to individual practices or practitioners.
2 Principles for a Healthy Working Environment

The following principles are designed to promote healthy working environments in the health and disability support sector. In its 2002 Framing Future Directions discussion document, HWAC identified an initial set of six guiding principles for healthy workplace environments. The initial principles have provided a basis for building the principles in this report, and have been revisited and enhanced in light of current research and practice. They have been supplemented by internal and commissioned research, and informed by consultation with the Technical Advisory Group.

The six high-level principles relate to aspects of the working environment that need to be addressed to create a healthy environment. For each of these principles, the Committee has identified a series of more specific sub-principles. These are specific qualities that describe healthy practice in each aspect in more detail.

The health and disability support sector comprises a tremendous variety of different workplaces. Employment settings can range from large, physically static institutions such as hospitals, to a dispersed but linked series of small practices such as a Primary Health Organisation (PHO), through to individual practices or practitioners.

Similarly, individual workers can spend all their time in a single location to which patients travel, or practise in other people’s homes, workplaces or community settings. Practitioners may work in tightly-integrated teams with whom they interact on a daily basis, or practise largely on their own, only occasionally coming into contact with other health and support workers. Ownership and resourcing arrangements range from fully publicly-funded institutions, to NGOs and private businesses that receive a varying mix of private and public funding.

For this reason, the Committee has not identified specific measures that should be pursued to create healthy workplace environments, as it is unlikely that specific actions will be relevant to all settings. A large metropolitan public hospital, for example, is a completely different environment from a small rural NGO that provides home-based disability support services, which differs from an suburban general practitioner practice within a PHO.

‘The six high-level principles relate to aspects of the working environment that need to be addressed to create a healthy environment.’
The Committee has earlier concluded that the diverse nature of the health and disability support sector means that it is unable to provide a single detailed blueprint that is applicable to all environments (HWAC 2002).

To ensure that its advice is as applicable as possible, the Committee has concentrated on identifying the general outcomes that represent a healthy work environment. It is the responsibility of particular employers, employees and organisational groupings to identify how these outcomes are best achieved considering their own specific circumstances.

In this regard, the Committee would like to highlight the work of District Health Boards New Zealand and Magnet NZ. The work of these bodies concentrates on the hospital setting. However, the Committee believes that the tools and approaches being developed by these bodies can be adapted to other settings, or prove instructive to those developing healthy environments in their own organisation.

**RECOMMENDATION TWO**

The Health Workforce Advisory Committee recommends that the Minister of Health accept the principles identified by the Committee as a basis for developing healthy working environments in the health and disability support sector.

### 2.1 PRINCIPLE ONE: ORGANISATIONAL CULTURE

An organisation’s culture can be defined as ‘the norms, values, beliefs and behaviours that influence how people in a particular organisation work’ (National Health Committee 2001).

In other words, it refers to the intangible ideas, principles and accepted approaches to issues that affect the way in which people in an organisation relate to each other and the work that they do, and is ‘the way we do things around here’ (Davies et al 2000).

The most fundamental principle in developing healthy workplace environments is ensuring that the culture of an organisation supports healthy working styles and vice versa. As Varuhas et al (2003) point out: ‘while organisational support…[is] important, without a culture that makes taking advantage of these benefits acceptable, these more objective supports [are] all but worthless.’ Similarly, Lowe and Schellenberg (2001) argue that a:

> ‘healthy and supportive work environment is the crucial factor in creating robust employment relationships … Individuals with strong employment relationships tend to have helpful and friendly co-workers, interesting work, assess their workplace as both healthy and safe, are supported in balancing work with their personal life, and have reasonable job demands. High levels of employee trust and commitment, in particular, are linked to perceptions that their employer cares about them.’

The organisation within which people work must not only not hamper the implementation of healthy initiatives, but actively facilitate their development. This applies regardless of whether an organisation is responsible for directly operating one or more physical workplaces, or co-ordinating the activities of workers who practise in other settings such as homes, schools or other workplaces.

Organisational culture is a broad concept with many aspects. These include patterns of communication, the nature of relationships between different subgroups in the workforce, the tolerance (or otherwise) of cultural and personal diversity, and the handling of workplace errors (HWAC 2002).

One of the key aspects, however, is the need for organisational culture to be based less on authoritarian hierarchies and more on ‘network’ relationships that emphasise collaboration and teamwork. It has been noted that environments based on this second type of relationship are more effective in implementing quality improvement practices (National Health Committee 2001).

Another key aspect of organisational culture is the concept of professional autonomy. Such autonomy does not mean complete independence — workers must still practise in an equal and collaborative manner with their colleagues, and recognise and operate within the overall resource constraints of
their organisation. Autonomy has instead been defined as ‘the ability of clinicians to make timely decisions based on their expert judgement ... because they are trusted to act ethically, with expertise and take responsibility for the results of their actions’ (HWAC 2002).

THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY ORGANISATIONAL CULTURE.

A healthy work environment:
- will have the health and wellbeing of the person as its primary objective
- reflects a culture that values employees and promotes trust between staff
- demonstrates people working collaboratively as teams and forming constructive relationships to achieve shared objectives
- enables effective and open multi-level communication channels
- encourages and supports change and innovation
- fosters creativity
- promotes continuous learning
- has a risk management approach that supports staff and is not simply risk aversion
- recognises and adapts to changing work–life balance
- reflects a culturally aware environment that is supportive of, and responsive to, the increasing diversity of the workforce.

2.2 PRINCIPLE TWO: LEADERSHIP AND DECISION-MAKING

The second key dimension of healthy working environments concerns the governance of organisations. This has two main dimensions: the nature of leadership within an organisation, and the processes used to make decisions.

Leadership, the first of these two aspects, overlaps somewhat with the principle of organisational culture. Although ‘leadership’ as a concept is multidimensional and difficult to condense to a simple definition, it is possible to identify general characteristics. According to Drucker (1996, cited in Perkins 2004):

- Leaders have followers, rather than subordinates. Without followers there can be no leaders, and becoming a follower is a voluntary decision.
- Leaders’ followers do the right things and achieve results.
- Leaders are highly visible and consequently set examples for others to follow.
- Leadership is not about rank, privilege, title or money, rather it is about taking responsibility.

Leadership can therefore be constructed as a motivating aspect of governance – the quality that makes an organisation move in certain directions and provides the momentum to ensure that things occur.

The second aspect of governance consists of the way in which decisions are actually made in an organisation. With regard to the health and disability support sector, the Committee would specifically like to highlight the position of clinical governance. Although some debate continues over detailed definitions of this concept, at base it represents increasing the active involvement of health and support workers in their own management and administration.

Both these aspects of governance are key elements of healthy and well-functioning workplaces in the health and disability support sectors. Further discussion of both leadership and clinical governance can be found in section three of this report, and in Perkins (2004).

THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY LEADERSHIP AND DECISION-MAKING.

- Governance structures and systems support staff involvement in decision-making, implementation and the review of initiatives in their area of expertise.
Participatory management is commonplace with staff involved in decision-making in their area of expertise and influence. Partnerships are established between the management and clinical cultures. Clinical leadership and shared clinical governance are promoted. Professional autonomy and accountability is promoted and valued. Leadership is continually developed and supported at all levels of the organisation. Leadership focuses on people, their potential, their impact, and what makes them function optimally. Effective feedback systems are developed.

2.3 PRINCIPLE THREE: CHANGE MANAGEMENT

Change is an inevitable part of any working environment. Organisations will always need to adapt to changing circumstances and contexts, and the health and disability support sector is facing a period of particularly significant change. The potential negative effects of such change on health and support workforces are well-recognised, including reduced morale and increased cynicism.\textsuperscript{13}

Furthermore, developing healthy working environments will require change to existing processes and perspectives. Ironically, there is therefore a danger that implementing healthy workplace initiatives could actually create the stresses they are designed to avoid.

Managing change in an effective manner is thus a key element of healthy workplaces. Aspects of effective change management are discussed in more detail in section three of this report.

THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY CHANGE MANAGEMENT.

- Change is managed as a normal and ongoing characteristic of the workplace, and good processes and principles are evident.
- Organisations engage in change management processes that help build and maintain organisational trust.

\textsuperscript{13} See, for example, Hornblow and Barnett 2000; Armstrong-Strassen et al 2001; Blythe et al 2001; Decker et al 2001.
2.4 PRINCIPLE FOUR: INFORMATION AND KNOWLEDGE SHARING

As with many other elements of the health and disability support sector, a healthy working environment is reliant on information and knowledge being effectively collected and shared. In particular:

- Effective information collection and sharing makes organisations aware of issues in a structured way rather than through informal or ad hoc complaints.
- It allows organisations to develop appropriate strategies to address issues and open dialogues between employers and organisations.
- The collection and sharing of information within an organisation can itself be a valuable way of promoting a healthy organisational culture.
- Sharing information avoids duplication of effort and allows for ‘mentoring’ relationships and guidance by others.

This principle has three core aspects. The first of these is collecting information on the nature and needs of the workforce, the working environment itself, and the quality of the working environment. This includes using a variety of information gathering methods to capture knowledge about staff and the environment, from formalised research and evaluation processes to informal feedback systems or discussion groups. The related issue of monitoring is discussed in section three of this report.

The second aspect is ensuring that information is used appropriately. The clearest example of this is openly acknowledging and addressing where possible, needs and issues in the workplace once they have been identified. It is also important, however, to recognise that collecting and sharing information is fundamentally an avenue for improving the quality of an organisation’s activities.

For example, evaluations should not be punitive processes, but instead seen as opportunities to identify potential problems in the working environment and ways to resolve them, or to highlight what is working well. Similarly, organisations should not become overly focused on performance against a small group of indicators and forget that such indicators are inevitably abstractions of what they are representing. Such measures are a way to gain information and thereby enhance quality, and are not an end in themselves.

The final aspect focuses on sharing knowledge and information regarding both problems and best practice solutions. This information-sharing should occur both internally and externally. Internal sharing can occur between managers and clinical staff or, in large organisations, between different departments or divisions. External information-sharing can occur with similar organisations, the wider health and disability support sector, and other stakeholders where appropriate.

Being open about both the positive and negative aspects of an organisation allows barriers to healthy practice to be addressed within an environment of trust and collegiality. Furthermore, sharing such information externally allows organisations to identify common trends and problems, share methods of overcoming issues, and develop collaborative solutions to problems that cannot be solved in isolation.
THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY INFORMATION AND KNOWLEDGE SHARING.

- Excellent information is collected to assist organisations to understand their workplace and staffing needs.
- Demographic information is collected about staff and used to customise organisational design.
- Evidence about working environment success is collected and shared with staff and, where appropriate, the sector as a whole.
- Comprehensive information is regularly collected about staff satisfaction with aspects of their environment, and is used to inform future decisions and actions to promote a healthier workplace environment.
- Organisations co-operate and share information with each other to help gain a national picture of future trends.
- Knowledge and solutions are shared.

2.5 PRINCIPLE FIVE: CAREER DEVELOPMENT

The principle of career development refers to the need for staff to be appropriately supported as health and disability support workers. As the Committee has previously noted:

‘If the workforce is to be viewed as the [sector’s] most valuable asset, then this asset needs to be cultivated or it will depreciate. This involves energising staff and harnessing their potential over a period of time. Strong systems invest in staff and develop them through the “life cycle” of their employment. Workforce development applies to all staff and is a feature of a learning organisation’ (HWAC 2002).

This principle applies at all stages of an individual’s career. Initially, it mainly involves ensuring the existence of effective systems to orient new and inexperienced staff to a specific working environment, and providing opportunities for mentoring and peer support.

In mid-career it also involves ensuring that staff have opportunities to continue to refine their existing skills and develop new competencies.
In large organisations this may involve secondment to other parts of the provider, while smaller organisations might co-operate with each other to swap or host visiting staff. Many professions in the sector also have a strong research tradition, and organisations should recognise that staff may thus legitimately expect that they will be allowed to conduct research as part of their professional development.

Finally, this principle involves ensuring that experienced practitioners have their skills and knowledge recognised appropriately. This may be achieved by providing opportunities to move into advanced roles or positions (such as Nurse Practitioner roles), or giving staff members an increasingly extensive role in the organisation itself through clinical governance processes or acting as a representative of the provider at collective fora.

THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY CAREER DEVELOPMENT.

- Staff are developed throughout their employment by high-quality systems.
- Individuals are oriented to the worksite by their team.
- Career development opportunities are readily available.
- Research is recognised as a legitimate work activity where appropriate.
- Staff receive feedback on performance and are actively involved in their performance development plan.
- Training and continuing education/learning is conducted on-the-job and through professional agencies.

2.6 PRINCIPLE SIX: EMPLOYEE RECOGNITION

Employee recognition is closely aligned with the principle of career development. However, this principle refers not only to recognising the skills and experience of the workforce, but also acknowledging that health and support workers regularly work within environments characterised by high levels of pressure and stress. All workers must feel that their work is valued and that the challenges they face are not ignored by the rest of the organisation in which they work (HWAC 2002).

Employee recognition is often thought of in terms of remuneration, and the Committee would like to reaffirm its commitment to New Zealand’s workforce being appropriately and fairly rewarded for the work it undertakes. However, this should involve not only monetary recognition, but also less tangible rewards such as official recognition of excellent practice and achievement.

This principle also involves ensuring that the conditions under which people provide care and support are recognised, and that the workplace environment is adapted to account for this. As a result, the principle of employee recognition includes such measures as increasing flexibility in work schedules, redesigning workflows to reduce working hours, ensuring appropriate workloads through the maintenance of safe-staffing ratios, and the creative use of the available staff and skill mix within an organisation.

THE COMMITTEE BELIEVES THAT THE FOLLOWING CHARACTERISTICS CONSTITUTE HEALTHY EMPLOYEE RECOGNITION.

- Staff are expected to perform well and are recognised appropriately.
- Remuneration is fair.
- Workloads and skill-mixes are optimally designed.
- Casual labour usage is minimal.
- There is flexibility in job design and work arrangements.
- Clinicians take responsibility for making timely decisions based on expert judgement.
- Excessive levels of stress are recognised as an occupational hazard and actively managed and monitored, and effective processes are provided to support affected staff.
- Employee assistance is provided where appropriate.
‘THIS PRINCIPLE INVOLVES ENSURING THAT EXPERIENCED PRACTITIONERS HAVE THEIR SKILLS AND KNOWLEDGE RECOGNISED APPROPRIATELY’
3 Creating a Healthy Working Environment

The specific measures needed to create a healthy working environment will depend on a variety of factors. These include the nature of the working environment itself, the size and nature of the workforce and the people they treat and/or support, and the resources available to the service provider.

Nevertheless, there are certain general points that are relevant to the majority of workplaces. In order to successfully implement initiatives and strategies to create a healthy work environment, employers need to take particular note of the following areas.

- Change management processes.
- Management choices.
- The type of leadership practised.
- The extent to which clinical governance is common practice.
- Recognising and managing professional diversity.
- Effective monitoring arrangements.

The way in which organisations approach these issues can have a major impact on the success or otherwise of an organisation’s efforts to create a healthy work environment.

3.1 CHANGE MANAGEMENT PROCESSES

As noted earlier, the health and disability support sector is characterised by change. Innovations in clinical practice, technology and working conditions are likely to generate continued rapid change for the health workforce. Similarly, expectations around how practitioners approach their work are changing. The workforce is facing a number of pressures stemming from these changes, including new roles, role conflict, lack of job security, ‘tight’ resources, new technology, perceived lower standards of patient care, and increasing paperwork (Tovey and Adams 1999).

Furthermore, cultivating healthy workplace environments will itself require changes to established processes and working arrangements. Even though these will be beneficial in the long term, they still involve a level of disruption that can cause stress amongst the workforce.

The change management process undertaken to accommodate both natural evolution and the introduction of healthy workplace initiatives and strategies will be critical. However, effective change management is not only important in developing healthy workplace environments, but will also be a product of such environments. The Committee has previously

‘... finding processes that involve all organisational sub-cultures, including managers, medical clinicians, nurses, allied health professionals and the non-regulated workforce.’

...
identified one of the positive outcomes of healthy environments as being ‘a resilient and adaptive workforce that accommodates changes’ (HWAC 2002). Organisations that create such environments will be better equipped to deal with other changes in the future.

Challenges in change management process implementation include finding processes that involve all organisational sub-cultures, including managers, medical clinicians, nurses, allied health professionals and the non-regulated workforce. These processes will also need to build and maintain the organisational trust that is crucial to the development of healthy workplace environments. Crow (2002) argues that trust is vital for the development of shared values, organisational social capital, and the relationship between management and staff. Effective leadership is vital in setting the direction for change and driving the process, but little can be achieved in the long-term without the support and collaboration of those who work in the organisations.

3.2 MANAGEMENT CHOICES

The health and disability support sector will always be subject to an environment of constraints. Any decision relating to the sector therefore contains a prioritisation element – whether it is made at the level of an individual practitioner, those who manage a provider of health or support services, or the Minister responsible for a country’s health budget (National Health Committee 2004).

Implementing healthy working environments is no different. The way in which managers choose to allocate their discretionary spending will have a significant impact on the implementation of HWE strategies and initiatives. Although some strategies will be small and inexpensive, others – particularly in areas such as training and development – will require a significant investment of time and/or money.

Deciding how to allocate resources is a complex and difficult process. This is particularly true in the health and disability support sector, where there is often significant pressure from both clinicians and the public to support as wide an array of interventions as possible. Decision-makers in such an environment may feel pressured to place lower priority on supporting initiatives that address staff needs, in favour of increasing the availability of interventions.

The Committee recognises these pressures on decision-makers and available resources. However, HWAC believes that without appropriate investment in the workforce, the question of the availability of interventions becomes moot. Health outcomes will inevitably suffer if a sufficient number and mix of staff are not available, or if those that do exist practise in unhealthy environments that hinder the delivery of high-quality care and support.

Conversely, investing in the development of HWE has the potential both to improve quality of care and reduce the significant costs associated with high rates of workforce stress, burnout, and staff turnover. In this way, investing in healthy working environments can actually improve the financial state of an organisation.

The Committee therefore urges those involved in decision-making to make the development of a healthy working environment a key priority for their organisation. As part of this, the Committee believes that the Minister of Health should communicate such an expectation to decision-makers in the sector. One of the clearest avenues for such communication would be through inclusion in the Minister’s annual letter of expectation to the Chairs of District Health Boards.

Clearly, such an expectation could relate only to DHBs. However, the central position of District Health Boards in the health and disability support sector means that these organisations provide a good starting point from which HWE practices can flow out to the rest of the sector.

The Committee would also like to highlight the position of the private health and support sector. The Minister obviously has relatively little ability to influence those organisations that are fully privately funded. However, as a matter of principle, HWAC believes that the private sector should also be providing such environments.
RECOMMENDATION THREE
The Health Workforce Advisory Committee recommends that the Minister of Health communicate an expectation to the publicly funded health and disability support sector that it makes the development of healthy working environments a priority, and that the Minister strongly endorses the development of healthy working environments in the privately funded sector.

3.3 LEADERSHIP AND ORGANISATIONAL DESIGN14

The major constructs of effective leadership in the New Zealand health and disability sectors were identified by a group of senior managers and clinicians in 2002 as:

- listening and communicating
- encouraging and facilitating
- having a shared vision
- being goal-oriented and getting things done.

People with these attributes need to be encouraged into leadership roles.

Opportunities for health and disability sector employees to develop into leaders have previously been relatively limited. Performing in clinical settings has had greater standing with clinicians than engaging in leadership and change management in health care organisations.

However, the adoption of a range of initiatives is enabling change in some situations. For example, a member of a surgical team may be delegated the job of developing a clinical pathway. While undertaking this task, the employee can develop leadership attributes that can then be utilised and further developed in other roles.

Transformational leadership occurs when leaders ‘broaden and elevate the interests of their employees, when they generate awareness and acceptance of the purposes and the missions of the group and when they stir their employees to look beyond their own self-interest for the good of the group’ (Bass 1990). The health and disability sector needs this type of leadership which focuses on people, their potential, their impact and what makes them function at an optimal – rather than simply satisfactory – level.

Effective leaders with these skills are required across all disciplines and at all levels in the health care organisations of the future. Those in positions of authority in these organisations need to bring the best out of the workforce, irrespective of the seniority of its members.

Research shows further consideration should be given by healthcare organisations to organisational design. Drawing on Pawar and Eastman (1997), key aspects of such design should include the following:

- Organisations should have straightforward, easily understood organisational design structures. Uncomplicated structures with clear lines of responsibility and accountability have the greatest potential to nurture leadership.
- Organisations that emphasise the role and opportunity of taskforces, planning groups, working parties, and project teams are more empowering to members of the organisation than organisations which focus entirely on activities that take place at the workforce. This raises questions for leaders because the important clinical work is done at the operational level.
- The form of ‘governance should reflect the interests and concerns of the key groups’ working in the organisation. There are ‘market’, ‘clan’ and ‘bureaucratic’ models of governance. The clan model has been found to be the most effective when it comes to nurturing leadership within organisations.

3.4 CLINICAL GOVERNANCE

A healthy workplace environment enables quality clinical care to flourish, and also improves organisational performance and consumers’ health outcomes. The United Kingdom National Health Service (NHS) has defined clinical governance as ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high

14 The Committee would like to express its thanks to Professor Rod Perkins for his work on this issue.
standards of care by creating an environment in which excellence in clinical care will flourish’ (Scally and Donaldson 1998; Donaldson and Muir Gray 1998).

The central aim of clinical governance is to hold groups of professionals accountable for each other’s performance. Evidence shows that clinical governance requires a systematic and demonstrable culture change away from a culture of blame, and towards one of learning (Department of Health 1999).

Much of the clinical governance literature emphasises the importance of doctors and nurses working effectively with managers. Of course, the health and disability support sector involves many other critically important groups of workers – in particular, non-regulated workers, allied health professionals and those with specific technical roles. All these groups need to be embraced in the leadership of the clinical governance agenda as well as the organisation generally.

HWAC (2002) found that clinical governance is distinguished from other quality approaches by key features that are ‘a focus on leadership, organisational culture and quality strategies, and crucially, accountability for clinical quality by the board and management’. The engagement of clinicians and the persistence and commitment of senior managers was essential in organisations that have made progress in organisational redesign.

The concept of clinical governance has been expanded in the concept of integrated governance or ‘joined-up government’.15 Here the question of hierarchy is addressed by frameworks that emphasise the importance of both recognising and distinguishing between networking, cooperation, coordination, collaboration and partnership and their contribution to achieving the objectives of clinical governance. The point of this is that healthy workplace environments in the health sector must recognise the limitations of hierarchy. Clinical governance and related methods need to be embraced.

3.5 RECOGNISING AND MANAGING PROFESSIONAL DIVERSITY

Organisations and other communities often comprise different sub-cultures. Health care environments are extremely complex and contain diverse professional sub-cultures, often with different philosophical approaches to care. For example, doctors have been found to view patient treatment as an individual doctor-centred skilled performance with a curative

15 For discussion of the concept of integrated governance and rationale for its introduction see Institute of Public Administration of Australia 2002.
orientation. Nurses view the same treatment as a collective, multi-disciplinary process, concerned as much with care as with cure (Degeling et al. 1998).  

Refusing to recognise such cultural differences can inadvertently give one group of practitioners more legitimacy than another, leading to one part of the workforce feeling marginalised and unappreciated. Furthermore, these cultural differences can lead to tensions – especially when attempts are first made to develop collaborative arrangements between different groups of practitioners.

There can also exist a cultural difference between those who practise ‘on the ground’ in the sector and are responsible for providing treatment and support services in specific areas, and those involved in management and administration who are responsible for ensuring that an organisation operates effectively and efficiently.

The quality of relationships between practitioners themselves, and between practitioners and management, is an important issue to consider when developing healthy working environments. Organisations must recognise and develop strategies to manage the diversity of these sub-cultures. These initiatives should be directed towards accepting the different approaches and understandings of practitioners in such a way that they can effectively work together as teams to achieve common organisational goals.

### 3.6 Monitoring

A basic principle of implementing any initiative is that its success or otherwise needs to be monitored. Without such processes, organisations will not be able to determine whether the strategies they have adopted are effective in achieving healthy working environments. In this regard, the Committee has recognised two different layers of monitoring: internal monitoring that an organisation carries out on itself, and external monitoring that is undertaken by a separate body.

The Committee has recognised the important role of internal monitoring within Principle Four: Information and Knowledge-Sharing. However, developing appropriate monitoring systems can require a significant investment of time and resources. The Committee thus believes that there is scope for the Ministry of Health to consider how it can provide support in this area, and develop advice measures for organisations to use in analysing their own performance in healthy working environments.

The Committee is aware that the diversity of the health and disability support sector makes it difficult to develop any sort of standardised performance indicators that are appropriate to all working environments. Appropriate indicators will depend on the nature of both individual workplaces and specific strategies being pursued.

The Ministry’s approach to such support should therefore be guided by a philosophy of flexibility and adaptability, and these indicators should be presented as aids for the sector rather than tools that organisations must use. The principles outlined by the Committee in this document should be used as the base for this work.

The question of external monitoring is more complex. The benefits of such reporting must be balanced against the time-consuming nature of such monitoring requirements and the previously noted diversity of the health and support sector. The Committee also notes that DHBs at least are already required to report to the Ministry on the actions they are taking to support healthy working environments as part of their normal reporting arrangements.

On balance, the Committee is not convinced that further external monitoring systems need to be developed. However, the Committee does believe that the Ministry should encourage DHBs to use the principles in this document as a framework for their existing reporting obligations.

#### Recommendation Four

The Health Workforce Advisory Committee recommends that the Minister of Health direct the Ministry of Health to explore how it can best monitor and support the development of healthy working environments.
Appendix One: Comparison of High-performing Practice Models

|----------------------------------------------------------|-----------------|--------------------------------------|-----------------------------------------|--------------------------------------------------|
| Employee autonomy and involvement in decision-making, including: | Principle 1: Organisational Culture | • Professional practice models of delivery of care  
• Professional autonomy and responsibility  
• Availability of professional advice  
• Emphasis on teaching responsibilities of staff  
• Decentralised organisational structure | • Employee participation programmes, cross-training or cross-utilisation  
• Participation and empowerment  
• Teams and job redesign  
• Symbolic egalitarianism  
• Enriched and shared jobs  
• Empowering human resource practices  
• Involvement/empowerment  
• Trust  
• Teamwork  
• Job rotation  
• Problem-solving teams  
• Extensive labour relations  
• Extensive employee involvement | 1. A workplace emphasis on participation, continuous quality improvement and productivity to enhance consumer-centred service delivery  
3. Culturally safe workplace and recognition of and respect for the Treaty of Waitangi  
4. Decision-making is devolved to the most appropriate organisational level together with clear lines of accountability  
5. An enabling multi-disciplinary environment supporting selected model(s) of care |
| Support for employee performance | Principle 2: Leadership and Decision-Making | | | |
| • continuous learning and acquisition of skills, for example appraisal systems, mentoring and coaching and train-the-trainer provision | Principle 5: Career Development | • Planned orientation of staff  
• Emphasis on service/continuing education  
• Competency-based clinical ladders  
• Management development  
• Development of clinical specialists  
• Adequate nurse staffing  
• Clinical career opportunities | • Training for future requirements  
• Training and skill development  
• Long-term perspective  
• Development  
• Performance-enabling work structures  
• Extensive employee orientation  
• Performance-based rewards  
• Continuous training  
• Training including coaching, mentoring and management development | 6. A professional and clinical learning environment in which teaching colleagues is integral to teams  
7. Appropriately qualified staff, resourced for sustainable service delivery  
8. Opportunities for health workers to develop within their chosen career through supporting ongoing relevant education and established competency-based career pathways  
9. A healthy and safe work environment and a flexible, worker- and family-friendly workplace |
<table>
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<tr>
<th>DIMENSIONS (ILO 2002)</th>
<th>HWAC PRINCIPLES</th>
<th>MAGNET CHARACTERISTICS</th>
<th>HIGH-PERFORMING PRACTICES</th>
<th>DHB/DHBNZ</th>
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<tbody>
<tr>
<td><strong>Rewards for performance</strong></td>
<td><strong>Principle 6: Employee Recognition</strong></td>
<td><strong>Flexible work schedules</strong></td>
<td><strong>Internal promotions</strong></td>
<td><strong>Principle 3:</strong> <strong>Change Management</strong></td>
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<td>- The use of systems designed to reward performance and motivate the employee</td>
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<td><strong>Performance based promotions</strong></td>
<td><strong>Participatory and supportive management style</strong></td>
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<td><strong>Skill-based pay</strong></td>
<td><strong>Well-prepared and qualified nurse executives</strong></td>
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<td><strong>Group-based pay</strong></td>
<td><strong>Information sharing</strong></td>
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<td><strong>Stock ownership</strong></td>
<td><strong>Accessible information flow</strong></td>
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<td><strong>Employment security</strong></td>
<td><strong>Communication</strong></td>
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<td><strong>Wage compression</strong></td>
<td><strong>Clear direction and goals</strong></td>
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<td><strong>Gain sharing</strong></td>
<td><strong>Overarching philosophy</strong></td>
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<td><strong>Incentive compensation</strong></td>
<td><strong>Effective management, professional and clinical leadership</strong></td>
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<td><strong>Performance management systems</strong></td>
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<tr>
<td><strong>Sharing of information and knowledge</strong></td>
<td><strong>Principle 3:</strong> <strong>Change Management</strong></td>
<td><strong>Information sharing</strong></td>
<td><strong>Principle 4:</strong> <strong>Information and Knowledge-Sharing</strong></td>
<td><strong>10. An organisational design that supports the principles above</strong></td>
</tr>
<tr>
<td>- Systems in place to communicate information to all employees, and also to ensure that feedback from employees reaches those responsible for the organisation’s strategy</td>
<td><strong>Participatory and supportive management style</strong></td>
<td><strong>Communication</strong></td>
<td><strong>Well-prepared and qualified nurse executives</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix Two: The Technical Advisory Group

FROM THE HEALTH AND DISABILITY SUPPORT SECTOR

Chris Clarke – Hawke’s Bay District Health Board

Judy Glackin – Ministry of Health

Kristine Kilkenly – Capital and Coast District Health Board

Jane Lawless – New Zealand Nurses’ Organisation Safe Staffing Enquiry

Janice Mueller – Auckland District Health Board

Jane O’Malley – New Zealand Nurses’ Organisation

Sue O’Shea – Public Service Association

Professor Rod Perkins – Auckland University

Dr Martin Seers – Pegasus Health

REPRESENTING THE HEALTH WORKFORCE ADVISORY COMMITTEE

Dr Clive Ross

Taima Campbell

Ian Wilson

SECRETARIAT SUPPORT

Paula Pietersma

Liz Stephenson


