Impact of a management assessment centre in developing proficient health managers

Ross Hartley and Wendy Garrett

Ross Hartley is Director of the Rural Health Education and Research Centre, Tamworth. Wendy Garrett is Senior Nurse Educator with the Rural Health Education and Research Centre and runs the Australasian Management Competencies Assessment Centre in Tamworth.

Abstract

There is growing use of management assessment centres within parts of New South Wales Health. The present study examined outcome benefits from managers who participated in the Australasian Management Competencies Assessment Centre®, some 123 staff from one rural and one metropolitan area health service. Results confirmed greater use of personal development plans and increased attendance at continuing professional development among participants compared with like managers who had not participated. The paper argues strongly in favour of widespread use of management competencies assessment centres as a way to implement planned cultural change.

Introduction

Too often employees take on the role of manager with little or no management training. As a consequence, the prevailing paradigm is one of learning on the job. According to Conant (1996), this can be very effective. He argues that, given the choice, the majority of managers choose experience over classroom education. At the same time, management practices worldwide are changing. While striving to keep abreast of changes in the workplace, managers must also deal with the additional challenges of downsizing, financial accountability and ethical dilemmas (Colon 1996). With limited resources available for management development because of competing demands for the scarce health dollar, it has

become even more important that organisations and individuals be able to identify and focus resources on the most important development needs.

Both theory and practice seem to emphasise the use of management development, or assessment, centres for personal development (Higson & Wilson 1995). Growth of these centres throughout the world is well documented. In the United Kingdom, for example, only 7 per cent of organisations used such centres in 1973, compared with 19 per cent in 1983 and 70 per cent in 1993 (Griffiths & Goodge 1994). Similarly in the United States, where 72 per cent of companies with at least 100 employees send managers to leadership training (Schlosberg 1996). By contrast, they are not common in Australia, particularly in the health industry. According to the Karpin Report (1995), less than half of the Australian companies surveyed made use of the notion of management competencies. Only 12 per cent assessed management competencies using management assessment centres; in fact, 40 per cent of companies were not even aware of the concept.

Against this backdrop, New South Wales Health has a demonstrable commitment to assessing and developing the management competencies of its middle and senior managers. Some rural area health services are more committed than others. Articulated in the New England Health Service (NEHS) business plan, for example, is the notion that all middle and senior managers will have completed a management assessment centre program within two years. Already, one-third of managers have done so. NEHS stands alone in its approach to management development in that it ties development of its managers to the notion of followership development, a hitherto completely ignored area of workforce development (Hartley 1996a).

The purpose of management assessment centres, in brief, is to use management simulations to enable managers to self-assess performance based on criteria validated as elements of management competencies. Something akin to using management games. It has long been recognised that the most effective tools in management training are work simulations that replicate real tasks and require participants to exercise skills relevant to the job (Fowler 1996). According to Hitchcock (1996), the most effective method for making training stick involves allowing managers to explore their own roles and the skills they bring to those roles, precisely what an assessment centre provides.

The management assessment centre used by NEHS was developed and validated by the Southern Sydney Conference Centre. Being both relatively inexpensive to run and easily transportable, the Australasian Management Competencies Assessment Centre^{R} (AMCAC) addresses the 10 key management competencies of leadership, influence, communication, people orientation, strategic planning,

innovation, analytical reasoning, decision-making, achievement orientation and resilience. It identifies an individual's strengths and development needs through a series of simulations that replicate management tasks and activities. These provide participants with the opportunity (using video and audio tapes) to assess performance against set criteria or indicators of expected behaviours, from which development plans are formulated. Situational Leadership analyses and Myers-Briggs Personality typing underpin the assessment centre.

The AMCAC has been running now for almost three years, mainly in the NEHS and the South Eastern Area Health Service (SEAHS) of Sydney. Several hundred participants have completed the three days. In view of this, it seemed timely to ask about the outcome benefits to host organisations. In other words, what evidence is there to validate the investment. To this end, a survey was undertaken late in 1996.

Materials and methods

A mail survey was undertaken during December 1996. The sample comprised four groups, each of about 50 middle managers randomly chosen. Half the sample were from SEAHS (metropolitan), the other half from NEHS (rural). Each group was further subdivided such that half had completed AMCAC and half had not. As much as possible, subjects in each of the four groups were matched by profession and level of responsibility.

The survey tool asked respondents to rate in order of importance the 10 competencies listed previously and to identify the three most needing personal development. Demographics and issues of professional development were queried. Using a scale 1 to 6 (1 being 'strongly disagree' and 6 'strongly agree'), subjects rated 20 attitudinal statements, 10 of which related to staff morale (Hartley & Turner 1995), the remainder being competency-specific.

Data were analysed using ANOVA, chi-square and factor analysis.

Results

Following a reminder notice one week after dispatching the survey, 123 managers responded; a response rate of 61 per cent. Fifty-two responses were from metropolitan managers and 71 from rural managers. Three times as many females responded than males, reflecting the actual gender distribution among health managers. Several hundred managers from SEAHS and less than 100 from NEHS had completed AMCAC at the time of the study.

Metropolitan versus rural comparisons

Demographic data suggested a reasonable match on age, income, discipline and qualifications for metropolitan versus rural comparisons. The major differences were that more of the rural sample consisted of people in the 50–59 age bracket (23.5 per cent compared with 15.4 per cent), and the complete absence of representatives from the medical profession in the rural subset compared with 13.5 per cent in the metropolitan subset. Although the metropolitan and rural groups showed some differences, chi-square analysis showed that only educational qualifications were significantly different (chi-square = 18.709, p = 0.0009, df = 4, Table 1).

Table 1: Qualifications of managers in metropolitan and rural health services

Qualification	Metropolitan (% of respondents)	Rural (% of respondents)
Postgraduate	48	22.4
Degree	34.6	25.4
TAFE	11.5	20.9
HSC	0	14.9
other*	5.8	16.4

*Mainly hospital-trained nurses

Ratings of the 10 management competencies by the metropolitan and rural managers were essentially the same, the only difference being the competency of resilience. Rural managers rated resilience as more important than their metropolitan counterparts (urban mean = 4.6 compared with 5.1 for rural, t = 2.379, p = 0.019, df = 120), possibly because they have fewer options regarding alternative employment. The need to bounce back therefore would be greater in the country. The two groups were similar in terms of those competencies most needing development, with strategic planning most mentioned by both metropolitan and rural managers (19.2 per cent and 19.1 per cent respectively). This was followed by analytical reasoning, innovation, resilience, leadership, influence, achievement orientation, communication, decision-making and people orientation. The latter was mentioned by 4 per cent of managers only, from both samples.

Staff morale, as measured using the Hartley and Turner (1995) tool, was essentially the same in both groups (65 per cent and 64 per cent respectively).

Despite the fact that SEAHS staff had undergone a recent controversial merger and restructure, there was no evidence from this survey that morale was any different from that in its rural counterpart, which had recently undergone only a minor restructure. Finally, in terms of attitudinal statements regarding performance on the 10 competencies, there were no differences between the two groups. Both saw themselves as having skills that veered towards excellence.

Participation versus non-participation in AMCAC

Subjects who had completed AMCAC were well matched in age, gender, income and qualifications with those who had not. Although the two groups exhibited some minor differences, chi-square analysis showed only those relating to discipline were significant. The differences clearly related to the absence of medical staff in the AMCAC group, the lower number of allied health staff and the higher number of health service managers (chi-square = 11.402, p = 0.044, df = 5, Table 2).

Table 2: Discipline representation for AMCAC group and non-AMCAC group*

Discipline	AMCAC group (%)	non-AMCAC group (%)
Nursing	58.2 (66.7, 55)	47.5 (47.2, 48)
Medicine	0 (0, 0)	11.5 (19.4, 0)
Allied health	10.9 (13.3, 10)	19.7 (16.7, 24)
Hotel services	5.4 (0, 7.5)	8.2 (2.8, 16)
Health service managers	16.4 (6.7, 20)	6.6 (8.3, 4)
Other	9.1 (13.3, 7.5)	6.5 (5.6, 8)

* Metropolitan and rural means, respectively, bracketed

There were significant differences in how the two groups rated the 10 management competencies (see Table 3). Those who had participated in AMCAC rated leadership, achievement orientation, strategic planning and innovation more highly than those who had not. Of the competencies most requiring development, strategic planning was the competency most identified by both groups, but more so by those who had participated in AMCAC. Communication and people orientation were identified by both groups as warranting little development (4.2 per cent and 3.6 per cent respectively for the AMCAC group and 9.6 per cent and 4.8 per cent respectively for the non-AMCAC group). This finding is at odds with much of the literature on management assessment.

Table 3: Mean ratings of management competencies for AMCAC group and non-AMCAC group*

Competency	AMCAC group	non-AMCAC group	Significance
Leadership	5.4 (5.5, 5.3)	5.0 (5.0, 4.9)	t = 2.328, p = 0.02
Influence	4.5 (4.5, 4.5)	4.2 (4.3, 4.0)	ns
Achievement	4.7 (4.8, 4.7)	4.0 (4.1, 4.0)	t = 4.117, p = 0.001
Strategic planning	4.6 (4.8, 4.5)	4.1 (4.2, 4.0)	t = 2.54, p = 0.012
People skills	5.2 (5.3, 5.2)	4.8 (5.0, 4.6)	ns
Innovation	4.5 (4.3, 4.5)	4.0 (4.1, 3.9)	t = 2.632, p = 0.009
Analytical reasoning	4.5 (4.2, 4.6)	4.3 (4.4, 4.1)	ns
Communication	5.6 (5.7, 5.6)	5.3 (5.3, 5.4)	ns
Decision-making	5.2 (5.5, 5.1)	4.9 (4.9, 4.9)	ns
Resilience	5.1 (4.7, 5.2)	4.8 (4.6, 5.0)	ns

* Metropolitan and rural means, respectively, bracketed

The major outcome from any management assessment centre is for participants to voluntarily contract and adhere to a personal development plan, working on those competencies and elements within competencies most needing attention. Results confirm that those who had participated in AMCAC did work to a personal development plan (chi-square = 7.446, p = 0.006, df = 120). Further, there was a significant difference in use made of continuing professional development. Those who had completed AMCAC accessed education 50 per cent more often than those who had not (AMCAC group mean = 4.8 compared with 3.2 for non-AMCAC group, t = 2.618, p = 0.01, df = 120). There were no differences between the metropolitan and rural groups in this regard. While there were no differences in morale of the two groups, those who had participated in the AMCAC felt they had more access to training (AMCAC group mean = 4.3 compared with 3.6 for non-AMCAC group, t = 2.52, p = 0.013, df = 120). Finally, in terms of attitudinal statements regarding performance on the 10 competencies, there were two notable significant differences between those who had participated and those who had not. The former rated themselves better at the competencies of communication (AMCAC group mean = 4.9 compared with 4.6 for non-AMCAC group, t = 2.1, p = 0.037, df = 120) and achievement orientation (AMCAC group mean = 5.2 compared with 4.8 for non-AMCAC group, t = 2.313, p = 0.0224, df = 119).

Discussion

Two desired outcomes from any assessment centre, and certainly from the AMCAC, are that participants work to a personal development plan and access training to enhance those competencies and elements within competencies with which they feel least comfortable. This study, the first validation of the AMCAC, confirms in no uncertain terms that both outcomes are being realised. The differences between those who had and those who had not participated were highly significant. And these outcomes were across the board, that is, in both the metropolitan and rural health services.

According to Karpin (1995), it is in people skills rather than technical skills that Australian managers are weaker and our international counterparts stronger. A study of 107 hotel managers by Tas, LaBrecque and Clayton (1996) identified interacting smoothly with a wide variety of people and operating under pressure as the most important of 18 competencies. Likewise, Shaw and Patterson (1995) reported that the highest rated subject areas in management development programs of Canadian hospitality managers (including health) were service quality, motivation and communication skills.

Against this backdrop, it was surprising that in the present study health managers rated leadership, communication and people orientation relatively high on the list of the 10 management competencies, yet cited people orientation as the competency least requiring development. This was despite the fact that feedback on leadership styles suggested the need for much improvement (Hartley 1996b). Interpreting this finding poses a conundrum. Is it simply that with so many competencies requiring attention, the newer ones resulting from devolution of senior executive control to a more team-based and flatter organisational structure get the attention? Much as we might like, it would be unrealistic to ask participants to develop all competencies; they do need to be selective. Or is it the case that being health workers, which brings with it a collage of caring type skills, they see themselves already proficient in the area of people orientation? Anecdotal evidence from participants during the Situational Leadership component of the AMCAC favours the first interpretation over the second.

Effective as the AMCAC appears to be, the fact that both the medical profession and, to a lesser extent, the allied health professions are under-represented is cause for concern. Our assertion is that management training is more generic than discipline-specific. A study of police promotions in the United Kingdom, for example, found that managers preferred management training of a generic rather than police-specific nature and far more exposure

to knowledge and experience of management theory and practice in non-police organisations (Gaston & King 1995).

And to the future! Managers are being asked to do more with less, to work smarter rather than harder. Any organisation committed to giving its managers the learning opportunity to self-assess competencies and to tie these to organisational and individual commitment to continuing professional development must have the competitive edge. Working from personal development plans is a far more effective way of ensuring cultural change than that of ad hoc attendance at training sessions, which we believe is more the norm.

References

Colon R 1996, 'Use of 360 degree assessment by public-sector management', *Employment Relations Today*, vol 23, pp 1–15.

Conant JK 1996, 'The manager's view of management education and training', *Review of Public Personnel Administration*, vol 16, pp 23–37.

Fowler A 1996, 'How to: Use games to choose winners', *People Management*, vol 2, pp 42–3.

Gaston KC & King L 1995, 'Management development and training in the police: A survey of the promotion process', *Journal of European Industrial Training*, 19, pp 20–5.

Griffiths P & Goodge P 1994, 'Development centres: The third generation', *Personnel Management*, vol 26, pp 40–3.

Hartley R 1996a, 'Integrating leadership and followership development – A rural health case study', *Asian Pacific Journal of Human Resources*, vol 34, pp 105–11.

Hartley R 1996b, 'Leadership as a management competency in rural health organisations', *Australian Health Review*, vol 19, pp 117–25.

Hartley R & Turner R 1995, 'Quality management: Influence of staff morale on customer focus', *J Quality in Clinical Practice*, vol 15, pp 3–10.

Higson M & Wilson JP 1995, 'Implementing personal development plans: A model for trainers, managers and supervisors', *Industrial and Commercial Training*, vol 27, pp 25–9.

Hitchcock D 1996, 'Learning from chaos', *Journal for Quality & Participation*, vol 19, pp 42–54.

Karpin D 1995, *Enterprising Nation – Renewing Australia's Managers to Meet the Challenges of the Asia–Pacific Century*, Report of the Task Force on Leadership and Management Skills.

Schlosberg J 1996, 'Learning to lead', *Computerworld*, vol 30, pp 81–2.

Shaw M & Patterson J 1995, 'Management development programs: A Canadian perspective', *Cornell Hotel & Restaurant Administration Quarterly*, vol 36, pp 34–9.

Tas RF, LaBrecque SV & Clayton HR 1996, 'Property-management competencies for management trainees', *Cornell Hotel & Restaurant Administration Quarterly*, vol 37, pp 90–6.