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THE CHANGING FACE OF MANITOBA HEALTH
A NEEDS ASSESSMENT

by

Robert A. Rauscher

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in Partial Fulfillment of
the Requirements for the Degree of
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**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree**

of

MASTER OF EDUCATION

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Abstract

Manitoba Health has and continues to undergo significant change, moving away from an organization that was involved in direct service delivery to one that now manages or supports service delivery through alternate models. This has created new and changing demands on the organization and on its staff. The purpose of this study was to identify Manitoba Health's desired level of skill sets for their staff compared to those which they currently possess. This was accomplished through the implementation of a needs assessment that focused on the identification and verification of the discrepancy or gap that may exist between these two states. That is, "what is" and "what should be". The specific questions that were answered by this research included: 1) what is the current and future mandate (role and function) of Manitoba Health under its new organization structure?; 2) What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?; 3) What skill sets does the staff of Manitoba Health currently possess?, and; 4) Does a gap actually exist between the current skill sets possessed by the staff of Manitoba Health and the desired skill sets as identified by executive management?

The study involved the collection of data from two target populations, both being part of Manitoba Health. The first target group was the five individuals who collectively formed the executive management team of Manitoba Health. Data collection from this group employed qualitative interviews and a quantitative rating scale tool. The second target

group involved 36 randomly selected staff from Manitoba Health who participated in the completion of specific components of a skills inventory tool developed by the Civil Service Commission, with particular emphasis on the seven core competency categories found within this tool. The data obtained from the staff respondents described the current staff skill sets or the "what is", whereas the data obtained from the executive management team described the desired skill sets or the "what should be". Comparing the two data sets provided a clear picture of what, if any, gaps existed between the current state and the desired state.

The results of the data analysis revealed that a measurable gap exists between what the executive management team identified as being the required skill sets within Manitoba Health as compared to those skills that Manitoba Health staff currently possess. This seems to be especially true in the core competency categories of Leadership and Thinking Skills. The recommendations made to address the existing gap include: 1) the development and implementation of a communication management strategy; 2) the development and implementation of a change management strategy; 3) the development and implementation of a training and development strategy; 4) the creation of a skill inventory database of all Manitoba Health staff; 5) that skill set and position/project matching occur, and; 6) the implementation of career development and succession planning workshops.

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Finally, I would like to thank my family who had to do without me while I immersed myself in the completion of this study. I am sure you were all glad to hear that it was finally completed.

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Chapter 1

An Introduction to the Problem

Rationale

Since the 1980's, governments around the world began a reform movement to create smarter as well as smaller public sectors. Cloaked under such descriptors as restructuring, reengineering, reinvention and renewal, the rapidly changing public sectors were striving to achieve similar goals - to improve the effectiveness and efficiency of the public sector, to enhance client services, to reduce public expenditure, and to create greater accountability of the public system (Boston, Martin, Pallot & Walsh, 1996).

With a growing national deficit, Canada was and remains one of those countries striving to achieve these goals. Determined to control and ultimately reduce the deficit, the escalating costs of the Canadian health care system was one of the first areas targeted. In 1966, a national Medical Care Act was proclaimed which provided for a 50/50 federal-provincial sharing of all medical costs delivered in Canada (Di Marco & Storch, 1995). However, as early as 1977, this funding arrangement was restructured into a provincial per capita block grant linked to Canada's

Gross National Product (Canadian Health Coalition, 1990; Fulton, 1993; Di Marco & Storch, 1995). While this restructuring of the 1966 cost sharing plan didn't immediately result in the reduction of federal transfer payments, the new funding formula did pave the way for the federal government to impose substantial downward adjustments in the years that followed (Asmonga, 1994; College of Family Physician of Canada, 1995). Manitoba, for example, received some 120 million fewer dollars in November 1992 as a direct result of reduced federal transfer payments (Canadian Hospital Association, 1993a).

All provincial governments were dramatically affected and most resented what was perceived as the "down-loading" of responsibility imposed by the federal government through reduced transfer payments (Northcott, 1995, p. 56). Nevertheless, the provinces also recognized their obligation of providing care to their residents and moved quickly to meet the fiscal challenge of managing their respective health care systems within current funding amounts. As Northcott (1995) suggested, the options available to the provinces to address this issue were limited. The first option was to increase taxes to offset the

reductions in transfer payments. Due to the predictive public resistance to potential tax increases (Spasoff, 1995), this option was quickly dismissed. The second, and only other viable option, was to restructure the existing health system in an attempt to gain greater efficiencies and generate cost savings. This left provinces, including Manitoba, struggling to reduce health care expenditures through restructuring strategies while maintaining access to high quality patient care (Leatt, Pink & Naylor 1996; Leatt & Leggatt, 1997).

In the Manitoba Throne Speech on March 7, 1991, the government announced that it would be moving to a "results-based government ... so that every tax dollar is used to its greatest effect"; this will be translated into developing "new delivery mechanisms and innovative management approaches" (Government of Manitoba, 1991, p. 5). As outlined in the 1992 government document *Quality Health for Manitobans - The Action Plan*, objectives for the reform of health care in Manitoba included:

- improving the effectiveness and efficiency of the health care delivery;

- the allocation of resources that would accurately reflect the health status needs of Manitobans;
- a reduction in the duplication of services;
- increasing the level of coordination and integration among programs and services;
- minimizing bureaucracy within the system;
- the consolidation of administration, and;
- involving the consumer within the decision-making process.

Both the 1991 Throne Speech announcement and the objectives contained within *The Action Plan* set the stage for unprecedented organizational change within Manitoba's health care system.

From its early beginnings in the late 1890's as the Provincial Board of Health (Wilson, 1945; Woods, 1938; Mitchell, 1934), Manitoba Health has been an organization that has endured many changes. In 1928, the Provincial Board of Health became a new government ministry known as the Department of Health and Public Welfare in response to its expanded role in the provision of health care services to Manitobans. Since that time, Manitoba Health has been continuously expanding its role under a variety of department names

but, for the most part, remained focused on the original 1928 mandate of the Department of Health and Public Welfare. That is, "the promotion of health and welfare of the people of Manitoba" (unknown author, 1928, p. 1). This mandate was achieved through the direct delivery and management of such programs as environmental services, preventative medical services, public health nursing, dental health services, laboratory services, and the northern health services (Department of Health, 1961). However, by the beginning of the 1980s, there were clues surfacing that an era of rapid and significant change lay just ahead.

With the release of the 1980 Department of Health Annual Report, the recognition of the need for change was clearly identified - "The Department of Health of Manitoba today faces a changing set of challenges. These have been shaped by influential trends which have become evident in the past decade; trends which reflect shifting social, economic and medical priorities" (p. 6). Over the next eighteen years that followed, but most notably from 1990 to 1998, marked a period in Manitoba where the health care system went through tremendous adjustment. There was a significant reduction of hospital beds through planned

closures, making many of the hospital staff redundant which lead to layoffs (Canadian Hospital Association, 1993b; Kierser & Wilson, 1995). The concept of reengineering became well known within Manitoba Health as downsizing, budget reductions and hiring freezes were exercised as part of cost containment strategies (Canadian Hospital Association, 1992, 1993d).

Still faced with the economic, demographic, environmental, social, political and technological forces of change (Trofino, 1995), in the early 1990's Manitoba Health adopted regionalization as an "explicit" goal of health care reform (Canadian Hospital Association, 1993c, p. 8). Vail (1995) described regionalization as the "transferring or "devolving" of responsibility for planning and allocating health care resources from a central government to a smaller local body" (p.60). Under the traditional government model, which Spasoff (1995) described as being clumsy in size and removed from the scene of health care delivery, health resource planning was performed by provincial bureaucrats (Vail, 1995). Regionalizing the delivery of services, as described in a Canadian Hospital Association report (1993c), would

maker it "easier for consumers and more effective for the providers" (p. 9).

On April 1, 1997, after several years of planning, the northern and rural regional health authorities officially became part of Manitoba's health care landscape. One year later to the day, both the Winnipeg Hospital Authority and the Winnipeg Community & Long Term Care Authority began operation, becoming the twelfth and thirteenth health authorities in the province. The regional health authorities have now effectively taken over the responsibility of a wide range of health care programs that were traditionally delivered and managed by Manitoba Health. Along with this transfer of program responsibility also came the transfer of hundreds of health staff members who became or are in the process of becoming regional health authority employees. This has left Manitoba Health as a changed organization, radically different than any other structure that has existed in the past. Manitoba Health now faces many new challenges as an organization that has reached the end of one phase of significant change, which, in turn, has marked the beginning of another.

The role and function of Manitoba Health has now been substantially altered, although exactly what that new role and function may not be fully understood. The reason for this lack of understanding can be related to the last eight years of change. Specifically, since 1990, this department had been reduced in staff through both internal downsizing efforts and regionalization. A hiring freeze was imposed by the provincial government that eliminated their ability to bring on additional personnel to replace staff openings created through attrition. With the creation of the regional health authorities, the responsibility for direct health care program delivery was largely removed from Manitoba Health. More recently, this department has lost key personnel who have been successfully recruited by the regional health authorities to fundamentally manage the same programs they had previous responsibility for. Manitoba Health now functions with a comparatively small compliment of staff who must effectively manage what can be described as a third party delivery system.

Kettl (1991) pointed out that many government departments, which were originally organized and structured for direct service delivery, are increasing

their reliance on non-government agencies and for-profit companies to deliver public services. It is suggested that while the attractions and benefits of having third parties delivery may be obvious, the new requirements placed on an administrative system moving from direct service delivery to alternate service delivery models are not. Kettl (1991) was clear on this issue:

Contracting out is not the same as direct service provision. It cannot be managed the same as direct government service delivery. Yet many governments have plunged headlong into contracting without taking stock of the new demands they will be facing. As a result, many governments find themselves struggling to manage contracted-out programs with people, processes, and structures designed for directly delivered services (p. 2).

In a 1995 internal working document produced by and for the Government of Ontario, much emphasis was placed on the area of "service system management capability" (p.8). Going through similar reform initiatives, it was identified that the restructuring of administrative services to an alternate model of service delivery would require new and/or different

service management functions within the civil service. The report went on to state that whether the services are acquired from external sources or be provided by internal organizations, the new or redesigned role of the service system managers will be to:

- define service requirements;
- convert these requirements into standards;
- acquire administrative services from the appropriate sources;
- ensure the service provider delivers the service;
- initiate corrective action where required.

Kettl (1991) added to this list, identifying the necessary skills of effective public managers as having significant technical expertise in the program area, as well as in accounting principles, financial management and information technology. He stated that "this is a very different skill set from that developed in managers of direct government programs, so it is difficult indeed to expect many government managers to take on these tasks without substantial retraining" (Kettl, 1991, p. 5).

Manitoba Health is well into the transition towards alternate service delivery models through the

development of the regional health authorities. However, there is now growing concern amongst executive management that the remaining staff within the department may not possess the required skill sets to properly administer the evolving program management delivery system. Therefore, the purpose of this research was to determine what the desired or needed skill sets for the staff of Manitoba Health are, comparing those against the skill sets that currently exist.

Definition of Terms

Need is a term which has caused much confusion in needs assessment due to a "lack of a generally accepted, useful, and substantive definition" (Pennington, 1980, p.2). Kowalski (1988) described need in terms of educational, felt, ascribed, real, normative, societal, organizational, created, and discrepancy and derived needs. Of the literature reviewed, the definition of need most frequently presented related to the notion of a deficiency. More specifically, a need has been described as "a gap between what ought to be and what is" (Boone, 1985, p. 115), "a gap between current outcomes or outputs and

desired (or required) outcomes or outputs (Kaufman & English, 1979, p. 8), and a "lack of something necessary or desirable good" (Houle, 1972, p. 134).

Scissons (1984) had a different perspective on the term need. He contends that needs are "nothing more than a construct; their attribution is inferred on the basis of data" (Scissions, 1984, p. 105), and that no single definition of need exists which could be used for every setting. Scissions (1982) proposed a three-component definition of need that could include any or all of the components - competence, relevance or motivation. Generally, competence refers to the ability of an individual to perform a range of skills; relevance refers to the utility of those skills within the individual's current situation; and motivation refers to the individual's predisposition to improve those skills. Therefore, within the context of Scissons' three-component definition of need, "a discrepancy need exists when an individual's competency in a relevant skill is less than desirable" (Kowalski, 1988, p. 125).

Needs assessment is a term that denotes a process that systematically collects and analyses the educational needs of an individual or organization

(Moore, 1980). Also described as a "tool which formally harvest the gaps between current results (or outcomes or products) and required or desired results" (English & Kaufman, 1975, p.3), needs assessment involves a number of steps: deciding to proceed, planning, developing focus questions, determining timeframes, collecting data, analyzing data, prioritization of identified needs, and reporting the results (Caffarella, 1994).

Skill, according to the Merriam-Webster Dictionary (1974), refers to the ability of an individual to use their knowledge effectively in doing something. Skill is also described as an acquired or developed ability. Based on a study of managers, Scissons (1982) provided examples of different skills such a group may need to possess: organize personal training, select or recruit staff, write business letters, set performance objectives, implement policy changes, etc. The term skill sets refers to a combination of different skills or set of skills that an individual would need to possess to perform a task effectively. How effective one is in applying his or her skills in order to accomplish something is referred to as competency. Therefore, competence refers to the ability of an

individual to perform a range of skills (Scissions, 1982). Core competencies are "skills or skill sets required of each job" (Civil Service Commission, 1998, p.3).

Manitoba Health is a line department within the provincial government structure that is responsible for establishing a framework for the planning and delivery of health care services. It is also within Manitoba Health's responsibility to foster "innovation in the health care system" through various mechanisms including the promotion of responsible and flexible delivery systems, and the development of alternative and less expensive services (Manitoba Health Annual Report, 1997, p. 10).

Statement of the Problem

In response to substantial reductions of federal health transfer payments, the Government of Manitoba has implemented major reform initiatives within their health care delivery system. The primary goal of the health care reform movement was to reduce health care costs through reorganization of the existing system, realizing savings through a more efficient and effective system. This was pursued mainly through the

development of regional health authorities that were charged with the responsibility of delivering and managing direct health care services; a role largely carried out by Manitoba Health in the past. This shift in health care delivery has translated into a leaner Manitoba Health, which has been left with a much smaller compliment of staff. In addition, this has also resulted in a change in the role and function of these staff, redirecting them from direct service delivery to management of a third party health care delivery system.

Today, executive management of Manitoba Health has a growing concern that the staff at the department does not possess the necessary skill sets to adequately manage their evolving roles and, therefore, will not be able to meet the current or future needs of the organization. While this concern may be valid, it should be recognized that neither the evolving role of Manitoba Health nor the desired skill sets had been clearly articulated to department staff prior to this study. In addition, there had been no attempt to identify the skill sets that the remaining staff possesses.

Given this, the purpose of this research was to identify Manitoba Health's desired level of skill sets for their staff compared to those which they currently possess. In other words, this research involves the performance of a needs assessment of the organization known as Manitoba Health. The specific questions that were answered by this research included:

1. What is the current and future mandate (role and function) of Manitoba Health under its new organization structure?

Manitoba Health has and continues to undergo significant change, being transformed from an organization that was involved in the provision of direct service delivery to one that is managing service through alternate service delivery models. Occurring in a very short period of time, this change has substantially altered Manitoba Health bringing into question both its current and future role and function as a department.

2. What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?

Executive management of Manitoba Health has expressed concern over the apparent lack of the

skills possessed by the current staff to adequately address the changing needs of the department. To date, there has been no effort to clearly identify exactly what those requisite skill sets are. Answering this question, in conjunction with the answer from the first question, will clearly established what the "desired state" for Manitoba Health is.

3. What skill sets does the staff of Manitoba Health currently possess?

Manitoba Health is comprised of a wide variety of talented individuals who have brought different skills to the organization. While developed and put to use in roles which may vary dramatically from future responsibilities, it is reasonable to believe that at least a portion of their current skill base will be transferable to address the evolving needs of the organization. An analysis or inventory of the staff's existing skill sets is necessary to establish the "current state" of Manitoba Health.

4. Does a gap actually exist between the current skill sets possessed by the staff of Manitoba

Health and the desired skill sets as identified by executive management?

By working to address the first three questions, the answer for last question becomes evident.

That is, it will become evident if a gap in skill sets actually exists between "what is", otherwise known as the current state, and the "what should be" or the desired state.

Significance of the Study

The results of this study were important to the executive management of Manitoba Health who must make critical staffing decisions on the reorganization of the department. In addition, the study's results provided executive management with the data required in making informed decisions on resource allocation to support staff training and development to meet the needs of the department. The study may also be of importance to other departments of health in different provincial jurisdictions where the same level of organizational change is occurring.

The main beneficiaries of this study include the organization known as Manitoba Health, its staff, and the clients that they serve. Executive management

staff who are directly responsible for the performance of Manitoba Health, can employ the results of the study in ensuring the staff are effective in supporting the organization's goals and objectives of the organization. Existing staff, through the executive management's sponsorship of this study, will have tangible evidence that the organization is committed to giving individuals appropriate career opportunities based on their current skill sets, as well as a visible commitment to ongoing staff training and development. Finally, an outcome of an organization that is operating more effectively, and that is meeting its performance objectives, will be improved service to the clients that it serves.

The following chapter is a review of the literature used to support the development of the needs assessment study of Manitoba Health.

Chapter 2

Review of Related Literature

Manitoba Health is transforming from a service delivery organization to one which Osborne & Gaebler (1992, p.39) have coined as a "steering organization". That is, an organization that has, for the most part, abandoned an operational capacity and adopted a much more catalytic role that sets policy, delivers funds to operational bodies and evaluates performance. The significance of this change has been dramatically heightened by the extremely short period of time in which it is occurring. What is the impact of such monumental change on an organization? How can an organization make appropriate decisions in response to change?

This review will be presented in two parts. The first, and more extensive of the two sections, focuses directly on the concepts of needs and needs assessment. This section will address the main premise of strategic planning for organizational change - examining whether the organization has the skills, abilities, and knowledge to achieve the goals identified as being necessary or desired (Bacal, 1993). The second part

considers the impacts that change have upon organizations.

Needs and Needs Assessment

It is not unusual to hear in everyday conversation, in an extremely wide variety of settings, the term need. Indeed, even within this document, need has been link with other terms including: health status, change, individual, group, organization and skill sets. Reference has also been made to educational needs, felt needs, ascribed needs, real needs, normative needs, societal needs, created needs, and discrepancy needs. This leads to two questions regarding need; "what is a need?" and "how are needs assessed?".

Much has been written about the concept of need. In fact, the plethora of information about need have created much confusion in attempting to define it (Sork & Caffarella, 1989; Brackhaus, 1984; Long, 1983; Pennington, 1980). Scissions (1984, p.4) took a much stronger stance on the concept of need stating that "needs are nothing more than a construct; their attribution is inferred on the basis of data". To him, needs are nothing more than an inference and,

therefore, do not exist. This view is supported by Mattimore-Knudson (1983, p.119) who suggested that the term need is a "hollow concept". However, even with the confusion over the meaning of the term need, and even with those who state that the term should be abandoned altogether, it remains to be an important concept in the educational milieu in terms of helping to define goals and objectives.

The Webster Dictionary (1989, p.956) defines need as "1) a requirement or a lack of something wanted or deemed necessary; 2) urgent want, as of something requisite; 3) a condition marked by the lack of something requisite; 4) necessity arising from circumstances of a case". Monette (1977) identified four major categories that the definitions for the term need can be placed: basic human needs, felt and expressed needs, normative needs, comparative needs and variant uses of the term.

Under the category of basic human need, Monette (1977) described the term need as a deficient state that initiates a motive by an individual or an inferred bio-psychological support. This description reflects the work of Abraham Maslow's (1970) hierarchy of needs concept. Maslow had segmented human need into 5

levels; physiological, safety, belongingness and love, esteem, and self-actualization. His belief is that individuals must first meet the most basic of all needs, physiological, before they will feel compelled to seek satisfaction at the higher levels.

Knowles (1980), when speaking to the concept of basic human needs stated that most psychologists agree that there are certain fundamental requirements common to all human beings, although there is no specific agreement as to what these needs are. Building upon this concept, Knowles (1980) created a list of what he believed to be basic human needs which includes: physical needs, growth needs, the need for security, the need for new experience, the need for affection, and the need for recognition. Tyler (1971) also identified what could be termed basic human needs, describing them as physical, social and integrative. However, Monette (1977) warned that given the general, and debatable nature of basic human needs, that this category of need does not facilitate educational decisions that have to be made by educators.

The second category of need Monette (1977) identified was "felt" or "expressed need". In this instance the term need is commonly used to describe an

individual's want, desire or felt need to achieve an ultimate goal. Kowalski (1988, p.123) stated that "felt needs are self-identified". He suggested that it is important to recognize felt needs within educational activities as some researchers believe that felt needs are the strongest motivators. Boone (1985, p.116) stated that all needs must be "felt" to serve as motivators for the individual. In addition, Boone recognized that "unfelt" needs are also important to consider, suggesting that many individuals may not know what their real needs are.

Monette (1977) presented a concern regarding felt needs. That is, a felt need is a stated desire from an individual's perspective, it should be recognized that it is somewhat limited by these same perceptions. As such, a felt need alone is not an adequate measure of what Monette referred to as "real" need. Brackhaus (1984) supported Monette's concerns stating that wants are based on personal standards which may not be desirable or necessary to anyone else other than the individual identifying them. Brackhaus also made reference to real needs that she described as "needs that actually exist" (p. 234). Kowalski (1988) saw

real need as a gap between present performance and a desired performance.

Under the normative category, Monette (1977) described need in a similar view that Kowalski (1988) had described real need. According to Monette, a normative need is one where there is a gap between a desired standard and the standard that actually exists. This need, where a gap between what is desired and what actual exists, is also know as a discrepancy need (Boone, 1985; Pennington, 1980; Kaufman & English, 1979; Houle, 1972; Nadler, 1978).

When placed within an educational environment, a discrepancy need has been used interchangeably with the term educational need. According to Tyler (1971):

studies of the learner suggest educational objectives only when the information about the learner is compared with some desirable standards, some concept of acceptable norms, so the difference between the present condition of the learner and the acceptable norm can be identified. This difference or gap is what is generally referred to as need (p.6).

Knowles (1980) described an educational need as a discrepancy between what individuals, organizations or

society want themselves to be and what they are. Boyle (1981), Kowalski (1988), and Caffarella (1994) provided similar definitions of educational need.

Witkin (1984) pointed to the discrepancy definition of need as one that can be used to define need at both individual and organizational levels. Within an organizational context, McBeath (1992) suggested that discrepancy needs at the individual level arise from the need to improve individual performance to better meet the objectives of the organization. Discrepancy needs at the organizational level result from environmental factors such as changing technology. Truelove (1992) warned that organizational needs are changing so rapidly that they may never be able to accurately predict all of their requirements. This, in turn, suggests that discrepancy needs within an organization may always exist to some degree.

Comparative need forms the last of Monette's (1997) categories of needs. Simply stated, this need is measured by comparing the characteristics of those receiving a service with those that are not. If the one group, typically those not receiving the service, fails to compare favorably with the group who received

the service, a comparative need is identified (Long, 1983). Monette once again warned that comparative need, by itself, is not an adequate measure of real need.

The entire concept of organizational need deserves further discussion. Robinson & Robinson (1996) identified four types of interrelated needs that will exist in most organizations, particularly if it is service-oriented. These included:

- business needs - which are the goals of the organization that are described and measured in quantifiable terms;
- performance needs - that are the job related behavioral requirements of people performing specific functions which collectively contribute in meeting the business needs of the organization;
- training needs - relate to what people must learn if they are to perform their job functions successfully;
- work environment needs - identify what systems and processes within the work environment must be modified if the performance needs are to be achieved.

Of the organizational needs listed above, the one need that becomes the most evident as a primary need is that of performance. Swanson (1994) suggested that performance needs exists at three different levels: organizational, process and individual. At the organizational level, the performance need relates to the organization's ability to meet the major functions that have been identified as comprising their mandate. At the process level, all processes need to work effectively and efficiently in order to meet the organization's requirements. At the individual level, the individuals within the organization need to be competent at the jobs they are performing so that they contribute to meeting the ongoing requirements of the organization.

Relating back to the discrepancy need previously identified, Rothwell (1996, p. 130) described a performance need as a difference or gap "between the way things are and the way they are desired to be". He offered six ways in which to conceptualize performance gaps:

- present positive gap - being described as the most desirable, this gap indicates that the organization is meeting and/or exceeding all levels of

performance standards it has established and is leading the way in best practices;

- present negative gap - is classified as a performance problem where the organization is not able to meet some or all of the performance standards set out for itself;
- present neutral gap - describes a situation where the organization's overall performance is neither a problem or an advantage, suggesting satisfactory performance but which places the organization at risk for possible stagnation;
- future positive gap - incorporates information about changes expected over time. The organization maintains its ability to meet its stated performance standards and plans effectively to meet future demands or needs;
- future negative gap - represents a situation where the organization is in peril. A recognized potential of a future gap should result in the initiation of corrective action over time;
- future neutral gap - once again describes a situation where the organization's overall performance is neither a problem or an advantage.

With today's pace of change, and the demand for greater efficiencies, it is unlikely that organization would remain satisfied with this type of gap existing.

One of the larger issues faced by administrators, managers and educators is to address the needs of their various client groups or organizations within an environment of scarce resources and competing priorities (Kemerer & Schreoder, 1983; Veres, 1980). This reality complicates the decision-making process for those individuals charged with the responsibility of effectively and efficiently facilitating substantial organizational change. Another compounding factor, as highlighted by Pennington (1980, p. 101), is that "needs will change in number and magnitude as the individuals and their environment changes". To meet this ongoing and significant challenge, many planners adopt and implement the needs assessment process.

The origin of the needs assessment concept has been linked to the social action legislation of the mid-1960s (Stufflebeam, McCormick, Brinkerhoff & Nelson, 1985). The identification and quantification of need became increasingly important as a basis to the determination of organizational goals and the funding

allocation to meet those goals. English & Kaufman (1975, p.3) have described needs assessment as both a "process" and a "tool". The description offered for needs assessment as a process included: a process of defining the desired end of a sequence of development, it is a method for determining if innovation is necessary and/or desirable, is an empirical process for defining the outcomes of education. As a tool, Kaufman & English described needs assessment as "formally harvesting the gaps between current results (or outcomes, products) and required results, places these gaps in priority order, and selects those gaps (needs) of the highest priority for action" (p.3).

Stufflebeam, et al (1985) identified that needs assessments serve two primary functions. The first function is to determine what needs actually exist and how these needs can best be met. The second function is that it can serve as a basis for evaluation by providing criteria against which the degree to which the needs have been addressed can be measured.

Stufflebeam, et al also suggested that the needs assessment process consists of five interrelated sets of activities: 1) preparing to do a needs assessment, 2) gathering desired needs assessment information, 3)

analyzing the needs assessment information, 4) reporting needs assessment information, and 5) using and applying needs assessment information. It was suggested that these steps do not necessarily have to take place in a strict sequential order due to the dynamic environment under which most needs assessments are conducted.

While not as prolific as the number of definitions for the term need, there exists a substantial number of needs assessment models that can be employed for conducting a needs assessment. Witkin (1984) pointed out that no one model or conceptual framework for needs assessment has gained universal acceptance, and that little evidence exists which support one model over another. According to Witkins, a model is a "conceptual framework for planning and conducting needs assessments, sometimes with the inclusion of strategies for gathering and analyzing data and setting priorities" (p. 31). Further, she suggested that choosing a model for needs assessment can be simplified by framing the selection around the answers received to the following questions: Who wants an assessment?; Why is an assessment wanted?; What should be the scope of the assessment?; On whose needs will you focus and at

what level?; What kinds and amounts of data should be collected for your purpose?; What sources and methods might you use for data collection?; What can you invest in people, money, and time?; What needs assessment products meet your purposes, constraints and resources?.

Regardless of the model selected, there appears to be a core of steps involved which is consistent between each. Watanabe-Barbulesco (1980, p.77) identified sixteen general steps for major needs assessments:

- 1) Deciding to conduct a needs assessment;
- 2) Arranging for coordination of the needs assessment;
- 3) Specifying the purpose of the needs assessment;
- 4) Defining the scope of the needs assessment;
- 5) Assessing obstacles and restraints;
- 6) Informing and involving the community;
- 7) Identifying symptoms of broad need areas;
- 8) Identifying and selecting appropriate needs assessment techniques;
- 9) Setting criteria for measuring need;
- 10) Gathering needs data;
- 11) Summarizing the needs data;
- 12) Interpreting the data and identifying the needs;

- 13) Ranking identified needs;
- 14) Evaluating the study;
- 15) Reporting to the decision makers;
- 16) Implementing the findings.

These steps are also, for the most part, contained within the generic needs assessment model identified by English & Kaufman (1975) and Moore (1980), as well as Kaufman's (1988) systems approach to needs assessment. Witkin (1984) identified that Kaufman's system approach has had a strong influence on educational models of needs assessments.

Within the arena of organization development, a major focus of a needs assessment is on determining training needs. As in all needs assessment, the training needs assessment is a process which must consider such factors as organizational priorities, costs, resources, and the nature of the learning involved (Peterson, 1992). A proper and thorough training needs assessment will identify the type of the training required and will yield criteria that can be used to determine the effectiveness of the training efforts (Quiñones & Ehrenstein, 1997).

Much of a training needs assessment within an organization will focus on what Swanson (1994, p. 44)

has labeled as a "performance diagnosis". A performance diagnosis is described as a problem-defining model that will result in identification of the actual and desired performances at the organizational, process, or individual levels, as well as specifying performance improvement interventions. Swanson's performance diagnosis model is comprised of five steps: the articulation of the initial purpose of the diagnosis, the concurrent identification of performance variables, performance measures, and performance needs, with the performance improvement proposal being the final step in the process.

Roscoe (1992) offers a training needs assessment model which analyzes the performance of the organization. Specifically referred to as an analysis of organizational training needs, or AOTN, Roscoe states that its purpose is to identify where training can make major contributions to improving organizational performance. Within that context, the AOTN attempts to answer the what, when, where, why, who and how questions of an organization's current functionality and how it will function in the future.

The AOTN as a need assessment process contains many of the steps outlined by Watanabe-Barbulesco

(1980). Roscoe (1992) identifies the steps involved within an AOTN as:

- 1) Appoint a responsible person - the person responsible is given all of the requisite authority to request information, meetings and access to people;
- 2) Plan the AOTN activity - an overall project timetable or critical path for the AOTN needs to be developed and granted approval;
- 3) Collect and analyze information to identify issues and performance problems - the outcome of the stage is the identification of key issues and performance problems facing the organization;
- 4) Further investigate to identify causes and effects - a detailed analysis of the problems identified takes place within this stage, with only those as being labeled as important being further investigated;
- 5) Generate and evaluate solutions matched to causes - the full range of possible solutions to problems identified must be determined and evaluated for appropriateness;
- 6) Priority list - a priority list should be developed that describes the nature of the

problem(s), what training implications are, what other implications have been identified and the level of priority;

- 7) Report the results - a detailed report that outlines the findings of the assessment;
- 8) Implement proposals - once the recommendations have been accepted, then their implementation need to be planned in detail;
- 9) Review, modify, revise - the proposals implemented require monitoring, with feedback loops created linking back to the issues and problems identified and the solutions proposed.

Organizational Change - Workplace Learning

Managing change in today's world is not only a fact of life (Smye & Cooke, 1994; Belasco, 1990), it also represents the major responsibility for most managers within present day organizations (Gray & Starke, 1988). While the issue of managing change has been with us for some time, the speed in which change is occurring is rapidly accelerating. To emphasize this point, Rosell (1995) citing Daniel Keating, suggested that if the last 100,000 years since the emergence of man could be compressed into a single

year, it would take until the end of November for man to be grouped in urban centres supported by agriculture. The industrial revolution would have started in the afternoon on New Year's Eve day, with the informational technology era developing in the last few minutes. Accordingly, the changes presently occurring within Manitoba Health would have taken place within the last nanosecond.

Gray & Stark (1988) felt that change occurs at three levels; individual change, group change, and organizational change. Change at the individual level, while potentially disruptive to the individual who is directly impacted, is usually of little overall significance to the organization. The one exception where individual change could have an impact at an organizational level is when the individual holds a position of significance, such as the Chief Executive Officer of an organization. On the other hand, most organizational changes have their greatest effect at the group level. Changes at this level can impact workflow, job design, social organization, and communication patterns.

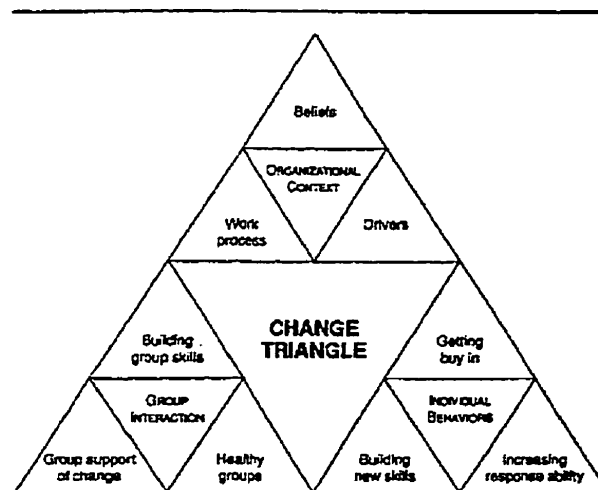
The final level of change identified by Gray & Starke (1988) is at the organizational level. Also

being referred to as organizational development, they suggested that change at this level involves major programs that affect both the individual and the group. Such large-scale change is typically driven by senior management of an organization and is very often in reaction to external factors beyond their control. The external factors that can necessitate organization change have been described as people, technology, information, fiscal pressure, globalization, growth of knowledge-based economy, concern about sustainable development, changing demographics, and increased accountability demands from stakeholders (Pritchett & Pound, 1995; Ulrich, 1994; McMillan & Murgatroyd 1994; Charner & Rolzinski, 1987). Organizations must be able to adapt quickly to remain both effective and efficient in environments of rapid change (Ulrich, 1994).

Presently, Manitoba Health is going through monumental change at the organizational level. To survive transitional change of such magnitude, Smye & Cooke (1994) suggested that organizations need a change management strategy and point towards their change triangle (Figure 1) that identifies three key issues that need to be addressed. They send a strong

warning that "change must be successfully implemented at every one of these three levels, or else the organization's new strategy is doomed to failure" (Smye & Cooke, 1994, p.355). Total commitment, from every level of an organization, is necessary to manage significant organizational change.

Figure 1- **The Change Triangle**



Smye, M. & Cooke, R. (1994). The key to corporate survival: Change begins with people. In L.A. Berger, M.J. Sikora & D.R. Berger (eds.), The Change Management: A Road Map to Corporation Transformation., (p. 356). New York: Irwin Professional Pub.

Smye's & Cooke's (1994) change triangle model focuses on three essential levels: organizational context, group interaction and individual behaviors. Each are further broken down into three subsequent components which have been identified as critical factors of success:

1) organizational context:

- a) beliefs - an organization's belief system involves vision and values; business purpose and strategy; its notions about its strengths and weaknesses; and its attitudes.
- b) performance drivers - are the forces which shape people's action and include goals, key results, reporting systems and reward systems.
- c) work processes - reflects how work flows through the organization, both vertically and horizontally.

2) group interaction:

- a) building group skills - build the hard skills such as problem-solving abilities, communication skills, and team skills required for group interaction.
- b) healthy group systems - understand and foster the characteristics for health groups that

centre on clarity of purpose, innovation, healthy discourse and crisp decision-making.

c) group support of change - gain group support for change which, in turn, will promote individual acceptance of change.

3) individual behaviors:

a) gaining buy-in - no organizational change be achieved until individual buy-in is achieved.

b) increase response ability - increasing individual responsibility and accountability will improve an employee's capacity to cope with change.

c) building new skills - in order to execute change, it is essential to build new skills which will allow the individual to contribute more to the organization.

It is clear that the foundation of organizational change is built around individuals who collectively form the working groups that champion the goals of the organization. Bowman (1994, p. 343) stated that:

when the activities of the organization are changed, the behavior of its people must be changed accordingly. Only people - with their values, skills and beliefs - actually change

results. The real trick in human resource planning is to align the skills, competencies, values, and change readiness potential continuously with the requirements of the business situation and make them an integral part of the organization's change plan.

This statement reflects the growing importance of education and training in the workplace as reengineered and downsized organizations are becoming increasingly more dependent on a workforce that possesses new, transferable skill sets (Spikes, 1995; Saltiel, 1995; Swartz & Swinerton, 1995). To further support this point, Watkins (1995) suggested that over 75% of all workers will require retraining by the year 2,000 and some degree of continuous training support thereafter.

Historically, training has been micro in approach within most organizations (Kozlowski & Salas, 1997). This approach tends to focus specifically on the needs of the individual but seldom aligns to the needs or goals of the organization. The traditional approach to training is consistent with Gray's & Starke's (1988) theory of individual change as previously referenced. However, Smye & Cooke (1994), as well as Bowman (1994), argued that it is really only the individuals within

the organization that can successfully bring about organizational change. One can only draw the conclusion that when planning organizational change, the goals and objectives for the organization, otherwise known as organizational needs, must first be clearly articulated and remain to be the primary focus when determining the developmental needs of the groups or individuals which function within that organization.

Summary

The literature on needs and needs assessment is extensive, and at times lends itself to confusion and contradiction. However, the fact remains that the concept of need is very real, and in the current climate of rapidly changing organizations, needs at all levels must be clearly identified and appropriately addressed through a needs assessment process. Although many different models of needs assessment have been offered, each contain similar steps: deciding to proceed, designing the assessment, data collection, analyzing the data, and reporting the results. Ironically, even though the benefit of proper assessment and planning for organization change is known to generate positive results and outcomes, as

Quiñones & Ehrenstein (1997) point out thorough needs assessments are rarely implemented due to such factors as related costs and excessive time requirements.

For the purpose of this study, the definition of need adopted was that of the discrepancy need as described by Kowalski (1988) given that this study focused on defining the gap between Manitoba Health's current state and desired state. In addition, Rothwell's (1996) version of a performance need has also be considered. In regards to a needs assessment model, Roscoe's (1992) analysis of organizational training needs or AOTN will be followed. However, steps eight and nine, implementation of the needs assessments recommendations and evaluation of the outcomes following the implementation of the recommendations, will not be addressed as they are beyond the scope of this study.

The following section addresses the research methods used for data collection within this study.

Chapter 3

Research Methods

The purpose of this study was to identify Manitoba Health's desired level of skill sets for their staff compared to those which they currently possess. This was accomplished through the implementation of a needs assessment that focused on the identification and verification of the discrepancy or gap that may exist between these two states. That is, "what is" and "what should be". The specific questions that were answered by this research are:

1. What is the current and future mandate (role and function) of Manitoba Health under its new organization structure?
2. What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?
3. What skill sets does the staff of Manitoba Health currently possess?
4. Does a gap actually exist between the current skill sets possessed by the staff of Manitoba Health and the desired skill sets as identified by executive management?

Research Design

Research has been defined by Reaves (1992, p.8) as a "systematic way of answering questions about the world". Beginning with the formation of research questions and a research problem for the study, which is immediately followed by a comprehensive literature review, the next all-important step is to identify a research approach (Kovacs, 1985). According to Guy, Edgley, Arafat & Allen (1987, p.92) a research approach or design is the "plan of procedures for data collection and analysis undertaken to evaluate a particular theoretical theory".

The selection of a research approach is based on the nature of the study and its overriding purpose. Reaves (1992) identified four types of research studies that include:

- 1) descriptive research - has no purpose other than to describe a particular situation or event;
- 2) exploratory research - investigates phenomena or situations that are not familiar;

- 3) theoretical research - the main purpose is to test and evaluate theories by finding causal relationships among variables;
- 4) applied or evaluation research - describes any research aimed at solving real-world problems or making practical decisions about actions in actual situations.

Once the approach is determined, the researcher typically chooses a research design that incorporates either a quantitative or qualitative methodology. Guy, et al (1987) defines the quantitative methodology as "research which depends mainly on statistical measures to evaluate differences in variance and means in a variable presumed to have been measured" (p. 453). The qualitative methodology is defined as "research that depends mainly on direct observation and descriptive analysis of social interaction and outcomes in specific social settings" (p. 453). Reichardt & Cook (1979) go beyond a definition, considering the quantitative and qualitative methodology as its own paradigm, each with its own set of attributes. The attributes of the quantitative paradigm include: seeks the facts or causes of social phenomena with little regard for the subjective state; obtrusive and controlled environment;

objective; removed from the data - the outsider perspective; confirmatory and inferential; outcome-oriented; reliable - hard and replicable data; generalizable; particularistic; and, assumes a stable reality. Attributes of the qualitative paradigm listed were: a concern with understanding human behavior from the actor's own point of reference; naturalistic and uncontrolled observation; subjective; close to the data - the insiders perspective; descriptive and inductive; process-oriented; valid - real, rich, and deep data; ungeneralizable; holistic; and, assumes a dynamic reality.

Guy, et al (1987) saw these methods or paradigms as two different ways of approaching a research project that do not easily translate back and forth. Due to this, they cautioned against combining methods within a research project and advocate employing a single approach. There are, however, others that don't accept their view.

Reichart & Cook (1979) stated that researchers should not rigidly adhere to either the quantitative or qualitative paradigm. Instead, the researcher should freely choose a mix of attributes from both paradigms to best fit the demands of the research project.

Reichart & Cook (1979) offered three reasons why a combined method approach to research is of potential benefit: research usually has multiple purposes which can be better addressed through a variety of methods; when combined, the two methods can build off each other to offer insights not achieved through the use of a single method approach; and, recognizing that all methods have biases, the multi-technique approach allows the researcher to triangulate on the underlying truth. Triangulation, according to Bottorff (1997, p.230) refers to the technique where "the findings related to each method are used to complement one another at the end of a study to enhance theoretical or substantive completeness". Bottorff (1997) also supported the use of combined methods in research, however, she warned that each should be carried out without violating their respective assumptions.

Based on the research categories provided by Reaves (1992), this research study can be described as an applied or evaluation research design in that it attempted to define, and ultimately present recommendations that would address a real-world problem faced by Manitoba Health as an organization. In regards to the research method, both the qualitative

and quantification methodologies were used in a combined approach to better serve the needs of the research project. A multi-method technique approach to data collection was also employed, which is described in detail within this chapter.

Sources of Data

The population targeted to participate in this research project was Manitoba Health's executive management, as well as randomly selected individuals from the staff of Manitoba Health. Manitoba Health's executive management is comprised of five individuals who have divergent backgrounds and experiences. Two of the five executive management members have a health specific background, two have significant experience in labour and manpower issues, with the last individual having a financial policy management background. In addition, of the executive management members, only two have been with Manitoba Health longer than eighteen months.

Since coming together to form the new executive management of Manitoba Health, this group of senior public sector managers have functioned as a highly collaborative team reaching decisions and providing

policy direction based on their collective experiences. This needs assessment study relied heavily on the input and data collected from these five main individuals or otherwise described by Witkin (1984) as "key informants". Key informants are people with special knowledge or expertise in a field. In this particular case, the executive management team has both the knowledge and authority for the management and development of the organization known as Manitoba Health.

As provided by Manitoba Health's Human Resource Unit, Manitoba Health has a current staff compliment of 1,085 people. This is in stark contrast to the over 2,686 people that were directly employed by Manitoba Health in 1995, which marks a period of time when the regional health authority service delivery model was at the conceptual stage. This significant downsizing was achieved mainly through the transfer of Manitoba Health programs and staff to the regional health authorities over the last two years. Eligibility and selection for participation in this research study is discussed in the next section.

Selection of Respondents

Witkin (1984) identified three methods used to select respondents to participate in a needs assessment as surveying the total population, to draw a sample, and to survey key informants. Guy, et al (1987, p.174) suggested that the surveying of an entire population is not common practice as "populations are usually too large, too obscure, or too inaccessible to study in their entirety". Other issues such as cost and time are significant factors that are taken into consideration. For these reasons, sampling of total populations provides a practical alternative.

Sampling is generally known as a way of obtaining data from a percentage of a total population and then generalizing the findings from this sample to the population (Kovacs, 1985; Sommer & Sommer, 1991; Reaves, 1992; Guy, et al, 1987; Fink, 1995b). According to Fink (1995b), sampling methods can be broken into two types; probability and non-probability. Probability sampling provides a statistical basis for stating that the selected sample is representative of the total population and implies the use of random selection. In probability sampling everyone in the target population has the same nonzero probability of

being in the sample group. Non-probability sampling is judgement based regarding the characteristics of the target population and the needs of the study. With non-probability sampling some of the targeted population will have a chance of being selected to participate in the study, while others do not (Fink, 1995b). Within each sampling method category exists a number of sampling types.

One of the target populations for this study had been identified as the executive management or "key informants" of Manitoba Health. All five this target population were requested to participate in the needs assessment research study, which represents 100% or total population selection. Kovacs (1985, p.100) defines total population as the "total membership of a defined set of subjects". While total population participation had been described being difficult to achieve, involvement of the entire executive management team was not only achievable but highly desirable as well.

The other population that was involved in the research study is the staff of Manitoba Health. Critical to the selection of participants from this population were the concepts of inclusion and exclusion

criteria. Fink (1995a) felt strongly that both criteria must be clearly defined so that those who fail to meet the inclusion criteria will be removed from the target population. Relating to this study, the inclusion criteria were: presently working in an area of Manitoba Health that has undergone, is currently undergoing, or is expected to undergo a change in role and function in the near future; and, is not delivering direct services to external clients. The exclusion criteria were: presently working in an area of Manitoba Health that has not undergone, is not currently undergoing, or is not expected to undergo a change in role and function in the near future; and, is delivering direct services to external clients.

Based on the activities of the different sections as described in the 1996-97 Manitoba Health Annual Report, the inclusion and exclusion criteria were applied to the 1,085 existing staff within Manitoba Health. The application of these criteria eliminated 729 from the target population leaving a total of 356 eligible to participate in the study. As it was not a possibility to involve the total target population in the study due to previously identified factors such as time and cost, a sample of the population was selected.

With this population, a probability sampling method known as a disproportionate stratified sample technique was applied. Guy, et al (1987) described this sampling technique as dividing the population into layers or strata, and then selecting the same sample size from each strata regardless of the overall population size of a strata.

The strata that have been identified for the purpose of this study involved grouping staff according to functional levels within the Manitoba Health and included: director/managerial level, professional staff level and administrative staff level. The operational definitions for these strata were:

- director/managerial level - describes individuals that has substantial responsibility and accountability for the operations of a branch or unit within Manitoba Health that includes budgeting, planning, and staffing;
- professional staff level - describes individuals that have been hired for a specific position in a branch or unit within Manitoba Health to support its daily operations based on their background, education and knowledge in an area of specialty;

- administrative level - describes individuals that that have been hired to provide administrative (clerical or secretarial) support in a branch or unit within Manitoba Health to support its daily operations.

With the sample framework now clearly defined, the next consideration regarding sampling of a target population was sample size. Generally speaking, the larger the sample size, the more closely the estimates approximate the actual values in a population (Gray & Guppy, 1994; Fink, 1995b; Guy, et al, 1987). Fink (1995b) suggested the use of complex statistical calculations to determine sample size, while others such as Kovacs (1985) identified that sample size selection can be less complex in approach. This might involve an approach where a simple percentage of the overall target population is selected as a sample size. Gray & Guppy (1994) pointed out that sample size should be linked to the purpose of the survey and acceptable sample size may vary dramatically.

As identified, 356 staff were eligible for participation within this research study. Taking the approach identified by Kovacs (1985), and based on a 10% sample, and rounding up to 360, the number of

respondents being sought was 36. However, Sommer & Sommer (1991) suggested increasing a sample size to address the potential of response refusal and spoilage. That is, the possibility of respondents who did not follow instructions, drop out of the study, or who terminate the interview prematurely, etc. For this reason, the desired sample size was increased to 42. With the aid of the Human Resource Unit of Manitoba Health, individuals were categorized as per the three strata in alphabetical and numbered order, with 14 respondents being selected through use of randomly drawn numbers from each.

Research Instruments

This research study relied on both qualitative and quantitative research methods for the collection of data. As pointed out by Carey (1997, p. 349) "qualitative approaches have been used in combination with quantitative approaches in sequence or concurrently to reinforce, explain, or expand". Several data collection techniques were employed for collection purposes: face-to-face qualitative interviews, which included the use of a rating scale; and, a self-administered survey that has been described as both a

quantitative and qualitative instrument (Civil Service Commission, 1998). Sommer & Sommer (1991, p.9) identified that "each technique for gathering information has its shortcomings" and advocate a multi-approach to data collection. They suggested that a multi-approach affords the researcher a degree of flexibility that is not possible with a single approach. As well, the major advantage is said to be the diversity of data collected and the opportunity for comparisons of data that this allows.

Patton (1990) described the purpose of interviewing as finding out what is in and on someone else's mind; to gain the perspective of the individual being interviewed. He suggested that qualitative interviews begin with the assumption that the perspective of the individual being interviewed is meaningful, knowable, and able to be made explicit. The task before the interviewer is to be allowed into the world of the person being interviewed.

Patton (1990) identified three basic approaches to collecting qualitative data through interviews: informal conversation, general interview guide approach, and the standardized open-ended interview. For the purpose of this study, the general interview

guide technique was utilized. Unlike the informal conversation approach, the guided interview draws on a list of questions or issues to be explored within the interview but are not as rigidly constructed and confining as the standardized approach. The interview guide forces the interviewer to predetermine how the limited time available for a interview will be used, as well as it allows for "systematic and comprehensive" data collection across a number of people (Patton, 1990, p.283).

A general interview guide (Appendix A) was constructed to focus the interview directly on the first two research questions of this study:

1. What is the current and future mandate (role and function) of Manitoba Health under its new organization structure?
2. What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?

The researcher, who constructed the interview guide, also conducted the interviews with the specific target population - executive management of Manitoba Health. The interview guide helped ensure that the interviewer stayed within the 60-minute time allocation

per interview. All interviews were tape recorded to capture "the richness and subtleties of the speech of the person being interviewed" (Tutty, Rothery & Grinnell, 1996, p. 67). Recorded interviews also permit the researcher to listen to the responses as many times as is required to allow for the coding of the responses, which is not possible prior to the start of this process (Rubin & Babbie, 1989). Each recorded interview was transcribed to supply the researcher with a hard copy to reference during the analysis phase. Although identified as an extremely time consuming task, transcripts are invaluable in data analysis (Patton, 1990).

A major influence on the questions and areas explored with the executive management was the ACCESS*MB*CSC skills analysis tool. Developed in Manitoba by the Civil Service Commission, Access*MB*CSC is an electronically based survey tool which is used to assess core competencies and employment skill sets of those completing the survey (Civil Service Commission, 1998), and was the tool employed within the staff population. In order to facilitate a linkage between the data collected from the executive management to that generated by the staff respondents, the executive

management was also requested to rank the core competencies contained within the *Acess*MB*CSC* tool. Each executive member was presented with a list of the core competencies (Appendix B), which they ranked as either very important, somewhat important or not important.

Data collection within the randomly selected staff population as previously identified was facilitated through the use of the *Acess*MB*CSC* self-administered survey tool. Self-administered surveys are one of the most commonly used methods for collecting data in research studies (Bourque & Fielder, 1995; Harrison, 1994). The data collected through this tool focused on addressing the third research question; What skill sets does the staff of Manitoba Health currently possess?

*Acess*MB*CSC* was developed following extensive research and development from multiple resources, as well as being field tested in Manitoba for reliability and validity. According to the Civil Service Commission (1998), the concept of validity was addressed through having experts in the targeted occupational groups review the questions for clarity, appropriateness and applicability. Field testing the tool addressed the concept of reliability, and having

the respondents review their results against the original questions to ensure that the data generated was an accurate reflection of their understanding and interpretation of the questions.

This tool has proven to yield useful data to aid in the areas of: skills inventories, succession planning, needs assessment and gap analysis, identifying training requirements and performance standards, designing new positions, and determining staffing requirements. The core competencies measured within the survey include: communication, managing for results, interpersonal skills, thinking skills, using information technology, leadership skills, and self-management. The categories of occupational skills contained within the *Acess*MB*CSC* are: managerial, administrative and related; natural sciences & engineering; social sciences & related; teaching, training & education; medicine & health; service; and, transportation, construction & trades. Under each of these occupational skills categories are a number of specific sub-groups that identify further areas of occupational specialty. There are also two other areas within this tool that allow the respondent to provide information on languages spoken/written and education &

training. All or some of the tool components may be used, depending on the purpose of the study (Civil Service Commission, 1998).

For this study, all occupational skills with the exception of the category of "managerial, administrative & related" were eliminated from use. Traditional occupational skill sets possessed by Manitoba Health staff were not the focus of this research study and therefore of no consequence. However, the same did not necessarily hold true for the "sub-groups" of the category of "managerial, administrative & related".

There may be any number of technical or clinical experts in Manitoba Health who have the skill sets identified within the category of "managerial, administrative & related" but who may not presently be functioning in a managerial capacity. For this reason, the sub-groups identified as financial, general management, and personnel & industrial relations were kept within the study.

The core competencies within the *Acess*MB*CSC* reflect what could be termed the skill sets of the future and, therefore, are especially important to this study. This is at least partially supported by McBeath

(1992) who believed that the three most critical competencies of the future manager will be superior interpersonal and leadership skills, above-average intellect and critical thinking skills, and computer literacy. All core competencies were kept and used within this study. Finally, the assessment area dealing with education preparedness was kept as it was anticipated that a percentage of staff sought education and training outside of Manitoba Health as part of their own plan for personal and professional development.

The design of the *Acess*MB*CSC* has been described by the Civil Service Commission (1998) as both a quantitative and qualitative tool. The quantitative aspect of the tool allows the researcher to generate statistical reports based on data collected through a rating scale. Rating scales, according to Sommer & Sommer (1991) are used to rank the respondents' judgements to questions, objects or events from high to low or poor to good. Within the *Acess*MB*CSC* tool the ranking scale is as follows:

- a ranking of "1" refers to an emerging skill base in a specific area;

- a ranking of "2" refers to an operational skill base in a specific area;
- a ranking of "3" refers to an in-depth skill base in a specific area;
- a ranking of "4" refers to an expert skill base in a specific area;
- no response is interpreted as the respondent having no skill base or experience in a specific area.

The qualitative component of the tool, as per the Civil Service Commission (1998), relates to the comment sections within the survey where the respondent can describe, in their own words, why they feel they have a specific level of skill in an area and provide examples. Without modification of instructions contained within the *ACCESS*MB*CSC*, respondents are directed to qualify their answer with a comment any time they response to a question with a ranking. For the purpose of this study, the respondents were asked to qualify their response in those areas with a ranked response of "in-depth" - #3 or expert - #4 (see limitations of self-answered surveys, pp. 79-80). This is because responses lower than a #3 were automatically interpreted as a skill area that would benefit from additional training and/or experience.

Although Bourque & Fielder (1995) defined a self-administered survey as an instrument used to collect data from the same people who complete it, they identify that there are actually four types of self-administered surveys. They are described as: one-to-one administration, group administration, semi-supervised administration, and unsupervised administration. The use of the ACCESS*MB*CSC, in its electronic format, requires all respondents to have a degree of computer literacy. In addition, this tool was not used in its entirety with specific areas of assessment being omitted. Due to these facts, the researcher had chosen the semi-supervised administration of the self-administered survey within this study.

The semi-supervised administration approach, as described by Bourque & Fielder (1995), allows the surveyor to answer questions about the survey, provide clarification on instructions, and monitor the data collection. It was anticipated that each respondent participating would have varying degrees of computer literacy and it was imperative that the researcher was available to provide technical support and assistance where necessary. On the chance that there were those

who possessed no computer functionality at all, a paper version of the survey was available. In addition, it was also anticipated that questions may arise regarding the omission of sections of the survey where the researcher can provide immediate clarification.

To provide details about the research study and the survey tools, two covering letters (Appendix C & D) were prepared to distribute to the respective target populations. The covering letter was a critical step within the research study that must meet specific criteria. Mason, Mcpherson, Hum, Roberts & Anderson (1983) identified these criteria as: provide a clear explanation of whom the survey is for; identify the purpose of the survey; ensure confidentiality and anonymity; ensure no personal information resulting from the survey will be divulged to a third party; offer access to the results of the survey in summary format; and, stress the importance of their participation based on the size of the sample. Mason, et al (1983) also suggested that the covering letter not contain promises of advancement based on participation, an indication that the survey is part of a thesis study, and avoids the overuse of the word survey as it is obvious. Particular emphasis needs to

be placed on the voluntary nature of participating in a survey, without penalty for non-completion or self-termination. All study participants were also requested to sign a consent form (Appendix E).

Data Analysis

Coding

Forty-two random letter codes, with six letters in each code, were generated and recorded on self-administered survey instruction forms. Each code was recorded on a master list, after which the instruction forms were folded and stapled in such a way that the code was not visible. These forms were then mixed so that the codes would no longer be in the same order as recorded. Within the semi-supervised administration setting, each respondent was given an instruction sheet by the researcher who drew attention to the code location on the form. The respondents used this code with the ACCESS*MB*CSC tool in place of their proper name. Respondents were told to retain this code name for their future reference and link back to the research study. Coding of the questions is as per the categories and sub-groups contained within the ACCESS*MB*CSC tool. Where generated, qualitative

responses were grouped and analyzed under the same category and sub-groups.

With the face-to-face survey approach, coding simply reflected a numbering system of "Interview #1" through "Interview #5". Rubin & Babbie (1989) had previously identified that coding of data collected through interviews is done once the data has been collected. However, it was anticipated that a large percentage of the responses would fit within the categories and sub-groups of the ACCESS*MB*CSC tool as it was used to aid in the construction of the interview guide.

Analysis and Reporting of Data

As identified, the data was collected through combined research methods; face-to-face interviews, with the inclusion of a rating scale, and the ACCESS*MB*CSC survey tool. Each method generated data that required a different approach to analysis and reporting.

The face-to-face interview, with the use of the interview guide as described by Patton (1990), is a qualitative research methodology. A technique described as "content analysis" by Kovacs (1985) was used in the analysis of non-quantitative data that can

not be immediately be expressed or treated as numbers. According to Patton (1990), data interpretation and analysis involves making sense out of what has been said. This is accomplished by looking for themes or patterns and then integrating this information with what the respondents had said. The interview guide was used to organize the data obtained from the interviews.

In addition to the interview guide, the rating of the core competencies performed by the executive management was summarized in table format. Of the seven core competency areas, each was ranked in order of importance to the organization.

The data collected by the *ACCESS*MB*CSC* survey tool utilizes a measurement scale described as ordinal (Fink, 1995; Kovacs, 1985). Fink (1995) described ordinal scales as typically seen in questions that call for a numeric rating scale of quality. Rating scales require the respondents to rate each item against specified criteria. Although numerical data is associated with quantitative methodology, Kovaks (1985) suggested that ordinal measurement could also be expressed in qualitative terms.

The *ACCESS*MB*CSC* survey tool contains a finite number of questions or variables to which all

respondents responded. Each of these variables has a limited number of values that a respondent can select from; numbers one through four. According to Guy, et al (1987) these variables are known as "discrete", as it is possible to list or count every value that these variables can assume. Guy, et al (1987) identified that the most common method for analyzing and summarizing the values of discrete variables is frequency distribution and percentiles.

The numerical data generated ACCESS*MB*CSC survey tool has summarized in a table and graph format, being analyzed by frequency of response and percentiles. That is, describing the number of times a response was given by the respondents per question or variable, and then indicating what percentage of the total response this represents. The comments that accompany the rating scale values have been analyzed to determine if any natural occurring categories or themes become apparent. All comments have been summarized, grouped by category or theme where applicable and reported on a competency by competency basis. No inter-group comparative analysis was performed, as the identification of the three functional levels was to facilitate the sampling selection process only.

Linking the Data

Critical to the needs assessment was the development of criteria against which the size of the gap between "what is" and "what should be" could be determined. The data collected from the executive management was intended to define the "what should be" which was clearly achieved through the content analysis of the interviews and rating of the core competencies. The data collected from the staff through the self-assessment tool, *ACCESS*MB*CSC*, was equally clear in establishing the "what is".

To compare the two sets of data, and to determine the size of the gap, the following criteria was applied. In those areas identified as being important to the organization by the executive management through either the interview process or the rating exercise, the following applies:

- 76 to 100% of the respondents self identify as having in-depth or expert skills in a specific area then no gap exists. Maintenance of that skill level within the organization is required;
- 51 to 75% of the respondents self identify as having in-depth or expert skills in a specific area then an emerging gap exists, which could be accentuated if

these individuals are not applying their skills within the organization. The organization would benefit from matching the skill(s) to tasks and/or projects, as well as developing further capacity within the organization;

- 26 to 50% of the respondents self identify as having in-depth or expert skills in a specific area then a significant gap exists. Purposeful efforts to match skill(s) to tasks or projects would be required, as would the development of capacity within the organization. The hiring of staff members with the requisite skill(s) requires serious consideration;
- 0 to 25% of the respondents self identify as having in-depth or expert skills in a specific area then an absolute gap exists. Matching skill(s) to tasks or projects will likely not address the need, nor would training and development strategies over the immediate future. Hiring individuals with the requisite skill sets is essential.

Maintenance of Confidentiality of Data

All data collected for this research study was kept at the researcher's office and placed in locked storage at all times. Access to this information was

limited to the researcher and the thesis committee. Data exists in recorded form, written form and electronic form. All electronic data was initially recorded on computer diskette by the researcher and then transferred to the researcher's desktop computer. The researcher's desktop computer was password protected, permitting access to only the researcher. The data on the computer diskette was stored under lock and served as a back-up data source in case of computer failure. The respondents' names were not identified within the data collected nor will they be used within any reports or published reports arising from the study.

Limitations

This study relied on the thoughts, opinions, and perspectives of five key individuals within Manitoba Health to identify both the current and future roles of the organization, as well as the desired skill sets for departmental staff. A collection methodology approach known as the key informant survey had been selected because it is "particularly recommended in the exploratory phase of a needs assessment to identify needs and issues that should be assessed in greater

depth by other means" (Witkin, 1984, p. 92). However, one of the most significant limitations of this collection method has been described in terms of its built-in bias. Specifically, Warheit, Bell & Schwab, (1977, p.21) suggested that this approach has an inherent bias as "it is based on the views of those who tend to see the community's needs from their own individual or organizational perspective".

An important premise of this study was that the staff of Manitoba Health is capable of providing a reliable and valid assessment of their own abilities, skills and knowledge when presented with a self-reporting survey instrument. This data collection approach has also been identified as one prone to bias as respondents may chose to give socially acceptable answers or to avoid sensitive or difficult issues (Harrison, 1994). The risk of providing bias responses is especially heightened when the research is being conducted by the organization regarding its own practice, where the respondents may be compelled to provide inaccurate responses to demonstrate their helpfulness or to make favorable impressions (Rubin & Babbie, 1989).

The final consideration is sample size of the respondent group, which according to Witkin (1984) has to be "large enough so that generalizations about the needs identified in the survey can be drawn to the target population". Involvement of the entire staff target population was not possible due to the reasons cited by Guy et al (1987) regarding size, accessibility, time and costs (see p. 53). A sample size of 10% of the staff target population was sought and achieved for the purpose of this study.

The following chapter presents a detailed analysis of the collected data.

Chapter 4

Results and Discussion

The questions that were addressed by this research included:

1. What is the current and future mandate (role and function) of Manitoba Health under its new organization structure?
2. What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?
3. What skill sets does the staff of Manitoba Health currently possess?
4. Does a gap actually exist between the current skill sets possessed by the staff of Manitoba Health and the desired skill sets as identified by executive management?

This chapter is presented in three sections, with each section addressing one or two of the research questions. Specifically, "Section A" will address research questions one and two through the analysis of the data collected from the executive management team. "Section B" will focus directly on research question three through the data collected from the staff

respondent group. Finally, "Section C" links the data from both groups and addresses the final research question.

Section A - Research Questions One and Two

The first two research questions were addressed through the involvement of the five members of the executive management team of Manitoba Health, which represented 100% participation of that target population. The executive management team, as identified, is comprised of five individuals each of who bring a wide range of experiences to Manitoba Health. The five executive members hold the positions of Deputy Minister of Health, Associate Deputy Minister of External Programs and Operations, Associate Deputy Minister of Internal Programs and Operations, Associate Deputy Minister of Human Resource Planning/Labour Relations, and Assistant Deputy Minister of Insured Benefits and Pharmacare Services.

Noted as the top bureaucratic position of the department, the Deputy Minister of Health began his career as a hospital administrator within small rural health facilities prior to going on staff with Manitoba Health. He had functioned for several years in

executive positions within the department until he took on his most current role as Deputy Minister in April 1997. The Deputy Minister is ultimately responsible for all aspects of the Department of Health.

The Associate Deputy Minister of External Programs and Operations began her career as a public health nurse in Alberta and moved to Winnipeg to assume a supervisory role in the same field. Continuing from that role, she assumed increasingly responsible positions within Manitoba Health up to and including her most recent position of Associate Deputy Minister. In this position she is responsible for all programs that are external to the Department of Health, which includes the regional health authorities and the development of that structure.

The Associate Deputy Minister of Internal Programs and Operations originally came to government in 1971 and first worked for the Department of Energy and Mines in the area of financial management. After leaving Energy and Mines, he joined the Department of Finance and the provincial Treasury Board where he was for approximately eighteen years. In 1997, he assumed his current role of Associate Deputy Minister where his strong financial and policy management background was

required to manage to the department's internal programs which is primarily budgetary in nature.

The Associate Deputy Minister of Human Resource Planning/Labour Relations first became involved with the Manitoba provincial government in 1982 being appointed as chair to the Advisory Council on the Status of Women. From there, she has worked with the Civil Service Commission in the area of pay equity, the Department of Labour as Deputy Minister, the Economic Innovation and Technology Council as president. In 1997 she joined Manitoba Health as Associate Deputy Minister to oversee the of health human resource planning and labour relations, primarily working with the regional health authorities and professional associations in these areas.

The Assistant Deputy Minister of Insured Benefits and Pharmacare Services has extensive government experience at both the federal and provincial levels. Within the federal government he spent some twelve years working in the area of investigations and audits. In 1987 he joined the provincial government's Department of Labour, having various responsibilities in the areas of pensions, employee services and environmental services. In 1997 he joined Manitoba

Health to assume his current position of Assistant Deputy Minister where he is directly responsible for all program areas related insured health benefits and the provincial drug program.

Interviews were conducted following a two part interview guide that kept each interview to approximately one hour in length. Part one of the interview guide focused on the mandate, role(s) and function(s) of Manitoba Health and was directed towards answering research question one. Part two of the interview guide focused on the required skill sets to meet the organizational needs of Manitoba Health and was directed towards answering research question two. After a comprehensive analysis of the interview transcripts, eight themes became apparent and are detailed below. The rating of the core competencies by executive management as part of the interview process also yielded critical information relating to research question two.

Theme One - Significant Change

All five executive management personnel identified two major changes that have profoundly affected Manitoba Health. The first change related to the transition of Manitoba Health from a direct service

delivery organization to that of an organization which manages an alternate service delivery model. Kettl (1991) describes this alternate service model as the reliance on third parties to deliver government programs. As identified by one of the executive members, Manitoba Health was an "organization that was predominately involved in the service delivery to Manitobans but it's no longer in the service delivery business". This transition has resulted in the devolution of Manitoba Health's operational responsibility and, in turn, caused a significant reduction in staff numbers.

The second change, which is directly linked to the first, involved the introduction of the regional health authorities as the new health service delivery agent. Being described by two of the executive management as the most significant thing that has happened to Health in years, the regional health authorities have assumed Manitoba Health's operational role(s) and the acquisition of a great number of their staff.

Theme Two - Mandate of Manitoba Health

It was identified that the overriding mandate of Manitoba Health had really not been altered dramatically with the introduction of the regional

health authorities. In fact, four of the five interviewed suggested that consensus regarding the mandate of Manitoba Health had been reached amongst executive management. In two of the interviews, that mandate was described as providing the best health care system that Manitoba can afford. However, equally represented was the view that this mandate was not well understood by staff. As commented on by an executive member, "is that (mandate) well understood within the department, I don't think so. As with a lot of transformation, I'm not sure that we have transformed ourselves well enough to understand what the final mandate will be."

Theme Three - Present Role(s) and Function(s) of Staff

Consistent within the interviews was a concern that the staff did not possess a complete understanding of what their present roles and functions were in the context of the organizational change that was occurring. It was felt that those who best understood their current roles and functions tended to be those who held higher level positions with Manitoba Health. It was also consistently identified that a large percentage of the remaining staff was being challenged

by new and increasing demands, which was forcing change within their current roles and functions.

In three of the five interviews, it was identified that the staff has become not only the managers, but also the catalyst for change within the health care system. They were expected to facilitate both the transition of direct service delivery to the regional health authorities, and at the same time manage their own change.

Theme Four - Changing Role(s) and Function(s) of Staff

Linked closely to the present role(s) and function(s) theme was that of changing role(s) and function(s). The first consistent observation made by the executive management team was that the staff was being challenged around moving away from being involved in direct program delivery to a less hands-on role. One executive suggested "that staff use to be worried about delivering programs and now they are concerned with issues like relationships, liaisons and program delivery from a distance".

The second consistent observation made was that the workload and volume demands have increased significantly for all staff, within radically shortened time deadlines. This has been complicated by the

growing demands being placed upon the staff "to function more like policy analyst and less like program managers".

Theme Five - Future Role(s) and Function(s) of Staff

The need to move the staff from being the "doers" of the work" to that of being the "assessors or analysts of the work" was re-emphasized. The staff of Manitoba Health have to be able to support the new role of the department whose evolving focus will be increasingly on legislation, policy, standards, contract management, program development, monitoring and evaluation, and funding and/or purchasing services.

Theme Six - Change Management Strategy

The need to have a well crafted Manitoba Health change management strategy was very strongly supported by four of the five executive members. Described by one of the executive members as "providing a map or critical path for the staff to follow", the main concern identified was that Manitoba Health never did have a change management strategy in place. All efforts had been focused on ensuring the successful development of the regional health authorities, which, unfortunately, left little time to manage the change within Manitoba Health. This, according to Smye &

Cooke (1994) could prove to be problematic to Manitoba Health as they firmly believe that organizations must have a change management strategy to gain total commitment from all staff in order to survive significant transitional change (see pp. 39 - 40).

Theme Seven - Organizational Needs and Skill Sets

There was overwhelming agreement that Manitoba Health as an organization had to ensure capacity in a number of key areas. These areas included: analysis, evaluation, research, policy management, decision-making, strategic planning, project management, issues management, and informational technology. These observations can best be supported through specific quotes and examples taken from each of the five individual transcripts:

- "Our biggest challenge is going to be developing the capacity to critically analyze the different priorities that we will face in the future";
- "We need people to evaluate, analyze and give us the information we need to base decisions on";
- "We need to do a better job in getting and making appropriate use of technology for decision-making";
- "We need to develop a research and policy group that is there to support the function of the department";

- "Project management will become a critical issue";
- "Issues management will be critical, which will likely be multi-divisional in nature"; and,
- "We really don't have a policy or research unit, nor do we have a strategic planning group".

Theme Eight - Organizational and Staff Development

Two major components of this theme emerged upon analysis. The first was the need to analyze the skills and competencies of the staff in order to create a skills inventory. The second was then to create opportunities for the staff to both maximize the career potential of the individual and benefit to the organization. As one of the executive explained, "we have to support training and development so that the staff can evolve as required to perform . . . leadership has to be committed to training and development".

As part of the interview process, the executive management were asked to rate the core competencies that were contained within the *ACCESS*MB*CSC* tool. The core competencies were broken down into seven distinct categories, with each having a set of competencies. These categories included: 1) Communications, 2) Managing for Results, 3) Interpersonal Skills, 4) Using

Information Technology, 5) Thinking Skills, 6) Leadership Skills, and 7) Self Management.

All executive management members participated and rated each against a scale of very important, somewhat important or not important. However, it should be noted that one of the executive management members had concerns regarding specific core competencies and questioned how "core" or essential they were. Examples of this issue included using presentation/multimedia packages, using spreadsheet programs, using the Internet, using word-processing packages, and designing web pages where he felt these were not core skills. In addition, the same executive management member had challenged the wording used to describe some of the core competencies. An example of this can be found in the core skill of "managing people" which was described as fostering high performance and managing resources. Managing resources was challenged as being part of managing people. This resulted in a number of non-responses for this member, leaving only four individual ratings of some of the core competencies.

The overall results of the rating scale component of the interview process yielded information consistent with that identified with the thematic analysis. More

specifically, theme seven - Organizational Needs and Skill Sets, had revealed the need for competencies in the areas of analysis, evaluation, research, policy management, decision-making, strategic planning, project management, issues management, and informational technology. These organizational and/or skill set needs closely parallel the core competencies contained within the ACCESS*MB*CSC tool. Further, the executive management were consistent in their assessment of the organizational and skill set needs as reflected in the results of the rating exercise.

Tables 1 through 7, which immediately follow, detail the results of the rating scale exercise achieved. The tables outline, by core competency category, how the executive management team rated each core competency or skill set which forms the baseline against which the current skill sets of the staff were measured against. These results are analyzed in greater detail in Section C - Linking the Results, where the data generated from the staff of Manitoba Health will be linked directly to the data generated by the executive management.

Table 1**Communications**

Core Sub-Skill	Description	Very Important	Somewhat Important	Not Important
A) Informing	passes information along on a timely basis	5	0	0
B) Listening	actively listening to understand	4	1	0
C) Speaking	speaking in a concise and clear manner to a variety of audiences	2	3	0
D) Writing	writing in a concise and clear manner	4	1	0

Table 2**Managing for Results**

Core Sub-Skill	Description	Very Important	Somewhat Important	Not Important
A) Demonstrating Business Skills	thinking/acting in an entrepreneurial manner	0	5	0
B) Ensuring Quality/Quantity	balances quality of results with quantity	3	2	0
C) Evaluating Results	monitoring performance and results	3	2	0
D) Managing Dollars	using budget dollars to achieve planned results	0	4	0
E) Managing IT	uses IT appropriately, effectively, efficiently	1	3	0
F) Managing People	fosters high performance, manages resources	4	0	0
G) Managing Projects	administration of a program involving multiple resources	2	3	0
H) Managing Time	plans and organizes tasks in a logical/concise manner	3	2	0
I) Organizing	schedules and coordinates work, prioritizes, meets objectives	3	1	0

Table 3**Interpersonal Skills**

Core Sub-Skill	Description	Very Important	Somewhat Important	Not Important
A) Customer Service	committing to help or serve others	3	2	0
B) Networking	builds and maintains broad informal network of contacts	1	4	0
C) Resolving Conflict	bringing conflict into the open and using it productively	1	3	0
D) Respecting Others	develops and maintains cooperative relationships	3	2	0

Table 4**Using Information Technology**

Core Sub-Skill	Description	Very Important	Somewhat Important	Not Important
A) Using Computer Aided Devices	computer workstation hardware	1	4	0
B) Using Computer Accounting Programs	one or more packages	0	4	0
C) Using Customized Computer Packages	to complete duties more effectively	2	2	0
D) Using Database Packages	one or more packages	0	4	1
E) Using Desktop Publishing	one or more packages	1	2	2
F) Using E-Mail/Intranet	using electronic mail as a communication tool	3	2	0
G) Using Presentation/Multimedia Packages	one or more packages	1	3	0
H) Using Spreadsheets	one or more packages	1	3	0
I) Using the Internet	one or more package	1	2	1
J) Using Word-Processing	one or more packages	0	1	3
K) Web Page Design	designing/updating web pages	0	1	3

Table 5**Thinking Skills**

Core Sub-Skill	Description			
		Very Important	Somewhat Important	Not Important
A) Analyzing	organizing elements of a situation, taking into account all factors	4	1	0
B) Applying Legislation	legislation, regulations, statutes, policies, etc	1	3	0
C) Applying Training/Development	applying new knowledge, skills, abilities, etc	2	2	0
D) Decision Making	reaching sound and timely decisions	4	0	0
E) Evaluating	weighing the significance of several inputs	4	1	0
F) Interpreting	understanding the meaning of a situation, concept or problem	3	2	0
G) Planning	participate in establishing the framework and processes for strategic planning	2	2	0
H) Problem Solving	diagnosing situation, identify the cause and offer solutions	5	0	0
I) Research	research written material, conduct interviews, etc	0	3	1

Table 6**Leadership Skills**

Core Sub-Skill	Description			
		Very Important	Somewhat Important	Not Important
A) Being a Team Player	working in a team environment	4	1	0
B) Creating Vision	translating vision into measurable value added goals/objectives	4	1	0
C) Displaying Initiative	demonstrating willingness to take on new challenges	4	1	0
D) Encouraging Innovation	for self and others	3	2	0
E) Ensuring Clear Values	ensures workplace values	1	3	0
F) Leading by Example	setting examples for other to follow	4	1	0
G) Motivating Others	increasing the productivity of others, creating positive attitude	5	0	0
H) Taking Calculated Risks	pursuing new opportunities	3	1	0
I) Understanding and Supporting Corporate Culture	understanding priorities, mission, etc	3	1	0
J) Valuing Diversity	respects workplace diversity	4	1	0

Table 7**Self Management**

Core Sub-Skill	Description	Very Important	Somewhat Important	Not Important
A) Demonstrating Coping Skills	developing/applying coping skills to stressful events	2	2	0
B) Demonstrating Flexibility	changing styles, adopt new approaches	1	4	0
C) Demonstrating Integrity	making actions match words	5	0	0
D) Demonstrating Motivation	personal motivation to do your best	2	2	0
E) Life Long Learning	using a variety of sources to obtain/maintain knowledge/skills	3	2	0

Summary

The executive management personnel interviews yielded rich data that served to address research question one relating to the Manitoba Health's current and future mandate. From the eight themes that emerged, the organization's current and future roles were clarified. Theme seven, when combined with the ratings of the core competencies as illustrated in Tables 1 through 7, clearly outlined what the executive management team felt the desired skill sets for the staff are that addressed research question two. The information within this section describes the "what should be" for Manitoba Health. The next section describes the "what is" state of Manitoba Health.

Section B - Research Question Three

Forty-two randomly selected Manitoba Health staff received letters of request, to which 37 or 88% responded favorably by participating in the study. Over the duration of the study, one of the respondents opted not to complete survey bringing the final participation rate to 36 or 85% of the target population. Rubin & Babbie (1989) suggested that response rates of 50% response was generally considered adequate, while a response rate of 70% was considered to be very good. Based on these criteria, a response rate of 88% and a completion rate of 85% which was achieved by this study would be considered exceptional. Beyond that, this response rate matched the sample size being sought, which was 10% of the target population or 36.

During follow-up contact with each of the respondents, and again within the context of the data collection sessions, repeated concerns regarding anonymity were voiced. More specifically, approximately one-third of the participants felt that providing detailed descriptions of the staff respondent group and/or use of specific examples provided within the completion of the skills inventory tool would

possibly reveal their identity to others within Manitoba Health. As such, detailed staff respondent demographics have not been provided within this thesis nor were specific examples supplied. However, in general terms, the staff respondents that participated in the study ranged in age from their early twenties to late fifties. The group was of mixed gender with approximately 70% being female. The respondents' years of service with Manitoba Health ranged from less than one year to more than twenty years. There was representation from all three strata of Director/Managerial, Professional and Administrative staff within the respondent group (see p. 56 for full descriptions). Based on the sample sized achieved, and the range of staff respondents randomly selected, confidence regarding the generalization of the following findings to the entire population of Manitoba Health is high.

The 36 Manitoba Health staff respondents that completed the *ACCESS*MB*CSC* skills analysis tool responded to the areas of: core competencies; managerial, administrative & related; languages; and education. The resulting data was extensive and extremely revealing. However, it became evident that

only the data collected within the area of core competencies provided a base for direct comparison against the data collected from the executive management thus allowing for a "gap" analysis. As such, the data collected in the areas of managerial, administrative & related, language and education has not been included within the main body of this research. Rather, the data has been represented in table format and included as appendices at the end of this thesis.

Core Competencies

The core competencies measured within the survey fell within seven categories and included: A) Communication, B) Managing for results, C) Interpersonal skills, D) Using information technology, E) Thinking skills, F) Leadership skills, and G) Self-management. Under each of these categories were a number of core skills that all respondents ranked their own individual skill base against a specific set of rating criteria (see pp. 65-66). The resulting data is listed below in a summative table format for each core competency category as well as in graph format for each individual core skill. Although extensive,

representation of the data using both formats provides a more vivid and comprehensive picture of the overall results achieved. In addition to rating their skill base, respondents were asked to provide supportive examples to qualify their rating selection. The examples provided by all respondents were grouped by core skill and analyzed for identification of any general themes or trends that would work towards illustrating the scope and nature of their collective experiences.

A) Communications

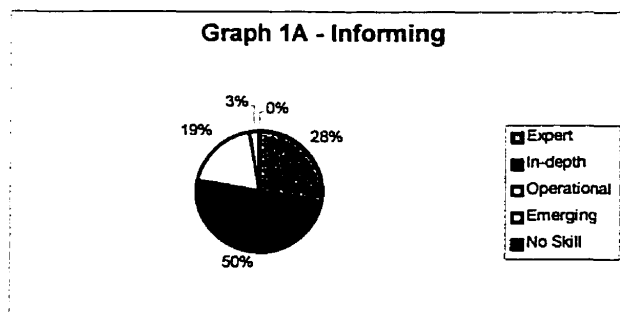
The first of the core skill categories is titled Communications, under which four core skill sets have been identified. Communications has been defined within the *ACCESS*MB*CSC* tool as:

Takes advantage of opportunities to listen to others and satisfy their need for information. Provides information and exchanges ideas in a way that promotes open and complete communication and understanding. Shares information clearly at the level of understanding of the audience and without holding back necessary information necessary to others (Civil Service Commission, 1998).

Table 8 below lists the four skill sets within the core skill category of communication and provides a working definition for each. On the right hand side of the table is the rating categories that include "expert" at the high end of the skill level and "no skill" at the low end of the skill level. The frequency of response is listed under each rating category.

Table 8**Communications**

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Informing	passes information along on a timely basis	10	18	7	1	0
B) Listening	actively listening to understand	11	19	6	0	0
C) Speaking	speaking in a concise and clear manner to a variety of audiences	8	17	10	1	0
D) Writing	writing in a concise and clear manner	7	18	10	1	0

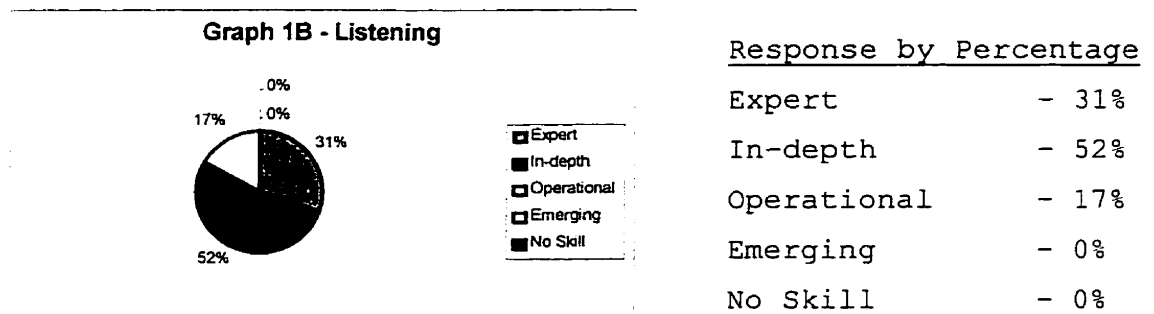
Frequency of Response By Skill With Theme(s)**A) Informing**Response by Percentage

Expert	- 28%
In-depth	- 50%
Operational	- 19%
Emerging	- 3%
No Skill	- 0%

Theme

- must communicate effectively with a wide range of individuals on a daily basis as part of my position responsibilities, informing them on an equally wide range of issues (28 respondents).

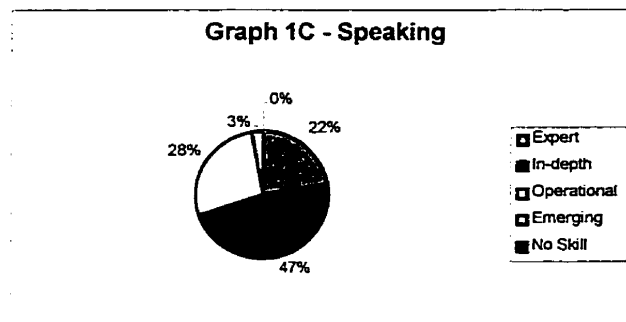
B) Listening



Themes

- deal with many complex and sensitive issues that require a clear understanding of the issue (9 respondents);
- interact with various stakeholders and clients in issues management which requires active listening (22 respondents);
- have taught or spoken on communications, focusing on listening skills (4 respondents).

C) Speaking

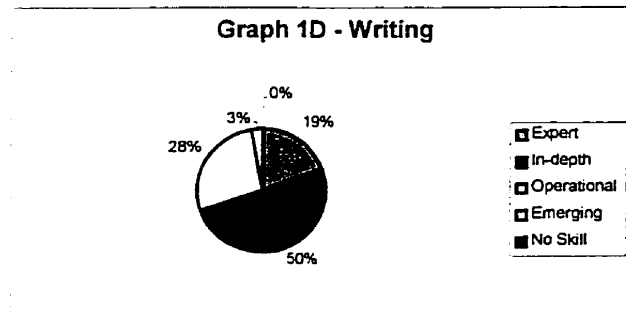
Response by Percentage

Expert	- 22%
In-depth	- 47%
Operational	- 28%
Emerging	- 3%
No Skill	- 0%

Themes

- experienced in public speaking within a number of settings that includes: conferences, Toastmasters, public meetings, and classrooms (17 respondents);
- well developed verbal communication skills plays an important part of my position (14 respondents).

D) Writing

Response by Percentage

Expert	- 19%
In-depth	- 50%
Operational	- 28%
Emerging	- 3%
No Skill	- 0%

Theme

- have prepared a wide variety of written communicates that includes: memos, letters, forms, brochures, reports, newsletter articles, briefs, submissions and public announcements (24 respondents).

B) Managing for Results

The second of the core skill categories is titled Managing for Results, under which nine core skill sets have been identified. Managing for results has been defined within the *ACCESS*MB*CSC* tool as:

Accepts ownership of projects, tasks, or programs, remaining accountable throughout the projects, tasks, or programs and delivers on commitments. Achieves results that are in line with corporate strategies by making the most efficient, effective, and appropriate use of resources. Recognizes opportunities to partner with other organizations to create synergy (Civil Service Commission, 1998).

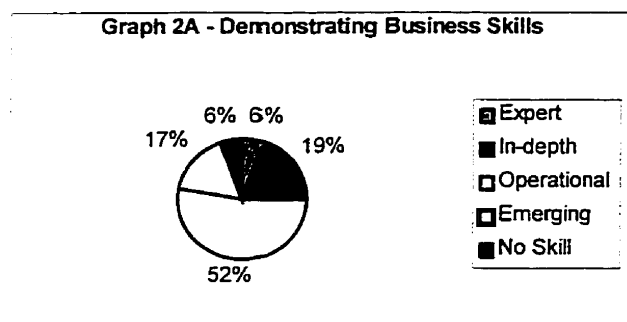
Table 9 lists the nine skill sets within the core skill category of Managing for Results and lists the frequency of responses of the respondents in those skill areas.

Table 9**Managing for Results**

Core Sub-Skill	Description	Expert	In-depth	Operationa	Emerging	No Skill
A) Demonstrating Business Skills	thinking/acting in an entrepreneurial manner	2	7	19	6	2
B) Ensuring Quality/Quantity	balances quality of results with quantity	2	17	14	3	0
C) Evaluating Results	monitoring performance and results	2	19	10	3	2
D) Managing Dollars	using budget dollars to achieve planned results	1	17	12	3	3
E) Managing Information Technology	uses IT appropriately, effectively, efficiently	3	16	13	4	0
F) Managing People	fosters high performance, manages resources	7	13	11	3	2
G) Managing Projects	administration of a program involving multiple resources	4	16	8	6	2
H) Managing Time	plans and organizes tasks in a logical/concise manner	2	17	10	0	7
I) Organizing	schedules and coordinates work, prioritizes, meets objectives	4	14	11	0	7

Frequency of Response By Skill With Theme(s)

A) Demonstrating Business Skills



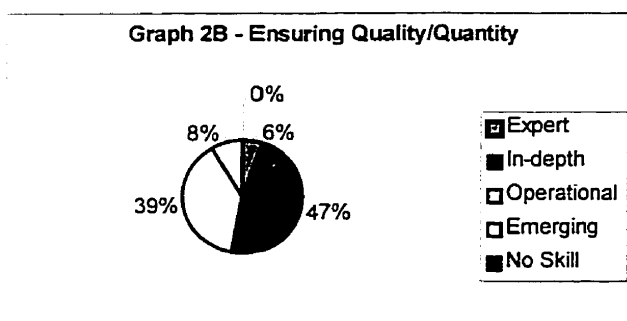
Response by Percentage

Expert	- 6%
In-depth	- 19%
Operational	- 52%
Emerging	- 17%
No Skill	- 6%

Theme

- have operated or currently operating a small business or consulting firm (9 respondents).

B) Ensuring Quality/Quantity



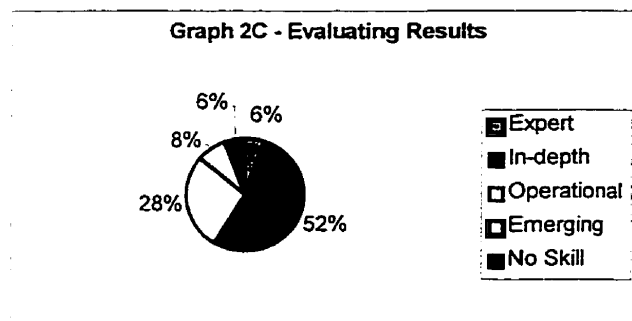
Response by Percentage

Expert	- 6%
In-depth	- 47%
Operational	- 39%
Emerging	- 8%
No Skill	- 0%

Themes

- involved in the implementation of total quality management and continuous improvement initiatives (6 respondents);
- analyzed and evaluated program proposals, assignments, service delivery to ensure quality of product (13 respondents).

C) Evaluating Results

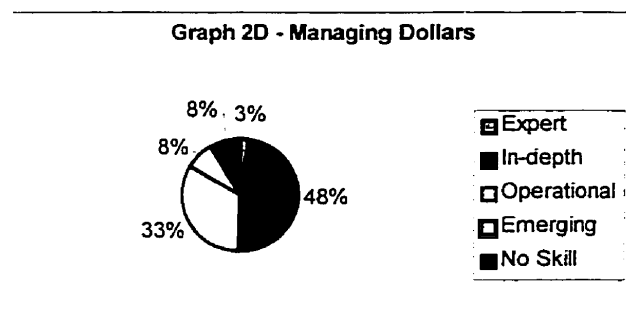
Response by Percentage

Expert	- 6%
In-depth	- 52%
Operational	- 28%
Emerging	- 8%
No Skill	- 6%

Theme

- evaluating the results of project and work efforts in my areas of responsibility (19 respondents).

D) Managing Dollars

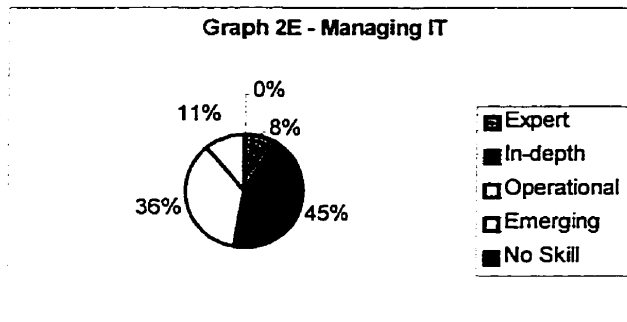
Response by Percentage

Expert	- 3%
In-depth	- 48%
Operational	- 33%
Emerging	- 8%
No Skill	- 8%

Theme

- responsible for a total budget or portion(s) of a program budget, ensuring appropriate accountability and reporting processes are adhered to (18 respondents).

E) Managing Information Technology

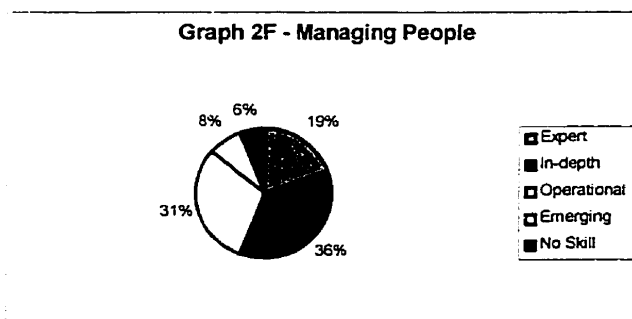
Response by Percentage

Expert	- 8%
In-depth	- 45%
Operational	- 36%
Emerging	- 11%
No Skill	- 0%

Theme(s)

- widespread use of information technology which ranges from that of word-processing, spreadsheet and data base applications to the Internet (14 respondents);
- willingness to continuously explore information technology and its application within the work setting (4 respondents).

F) Managing People

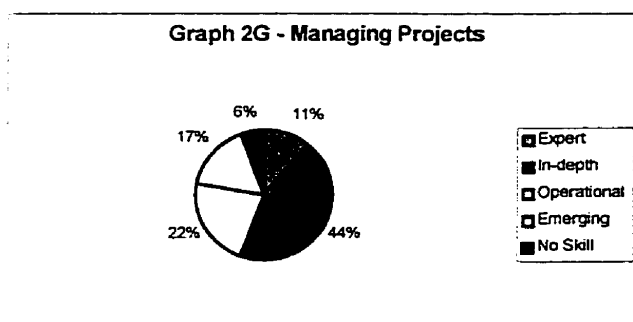
Response by Percentage

Expert	- 19%
In-depth	- 36%
Operational	- 31%
Emerging	- 8%
No Skill	- 6%

Theme

- in past and current roles, I have supervised and managed staff ensuring program/project/unit goals and objectives are met (19 respondents).

G) Managing Projects

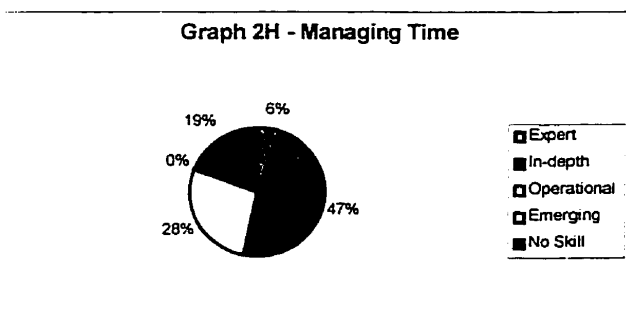
Response by Percentage

Expert	- 11%
In-depth	- 44%
Operational	- 22%
Emerging	- 17%
No Skill	- 0%

Theme

- project management forms a part of my past and/or current position responsibility, having managed all aspects of a project from concept to implementation and evaluation (18 respondents).

H) Managing Time

Response by Percentage

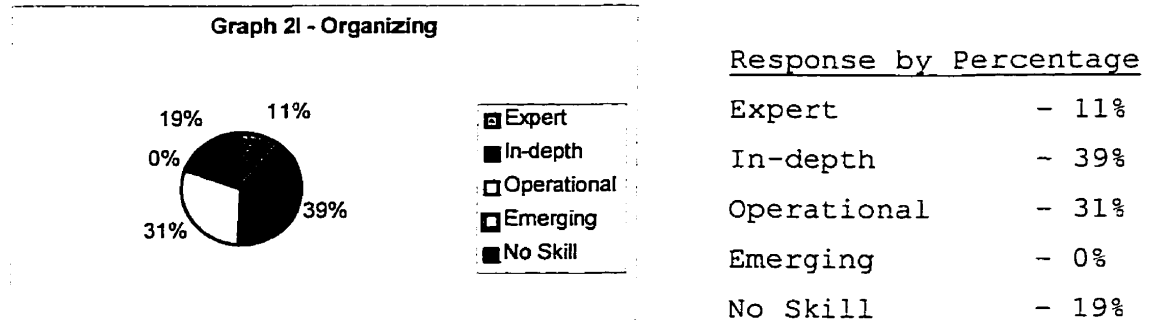
Expert	- 6%
In-depth	- 47%
Operational	- 28%
Emerging	- 0%
No Skill	- 19%

Themes

- time management is an important skill as we attempt to balance increasing work demands with other demands outside of the work environment (4 respondents);
- follows from project management where the development of such time line tools as critical

paths is essential for time management (13 respondents).

I) Organizing



Theme

- this skill is/was required to be effective in my current/past positions to meet both my daily and ongoing responsibilities (16 respondents).

C) Interpersonal Skills

The third of the core skill categories is titled Interpersonal Skills, under which four core skill sets have been identified. Interpersonal skills has been defined within the ACCESS*MB*CSC tool as: "Works to build or maintain effective relationships with internal partners, external partners and stakeholders whose cooperation is important to present or future success. Knows when to compromise and how to productively resolve conflicts" (Civil Service Commission, 1998).

Table 10 lists the nine skill sets within the core skill category of Interpersonal Skills and lists the

frequency of responses of the respondents in those skill areas.

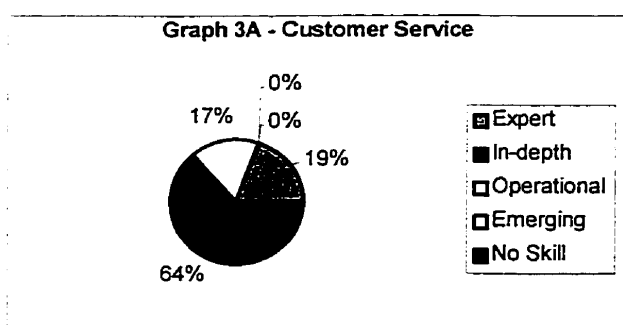
Table 10

Interpersonal Skills

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Customer Service	committing to help or serve others (internal & external customers)	7	23	6	0	0
B) Networking	builds and maintains broad informal network of contacts	4	20	12	0	0
C) Resolving Conflict	bringing conflict into the open and using it productively	4	19	12	1	0
D) Respecting Others	develops and maintains cooperative relationships	5	24	6	1	0

Frequency of Response By Skill With Theme(s)

A) Customer Service



Response by Percentage

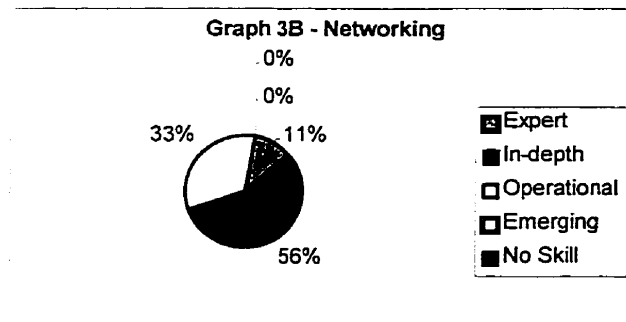
Expert	- 19%
In-depth	- 64%
Operational	- 17%
Emerging	- 0%
No Skill	- 0%

Themes

- customer service is a part of my daily responsibility, interacting with both internal and external clients (10 respondents);

- must meet frequent demands for information from a variety of internal and external customers (7 respondents);
- have facilitated focus groups and/or taught in the area of customer service (3 respondents).

B) Networking



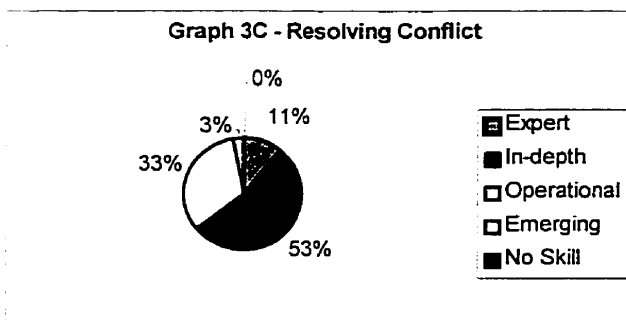
Response by Percentage

Expert	- 11%
In-depth	- 56%
Operational	- 33%
Emerging	- 0%
No Skill	- 0%

Theme

- this skill is/was required to be effective in my current/past positions to meet both my daily and ongoing responsibilities (24 respondents).

C) Resolving Conflict



Response by Percentage

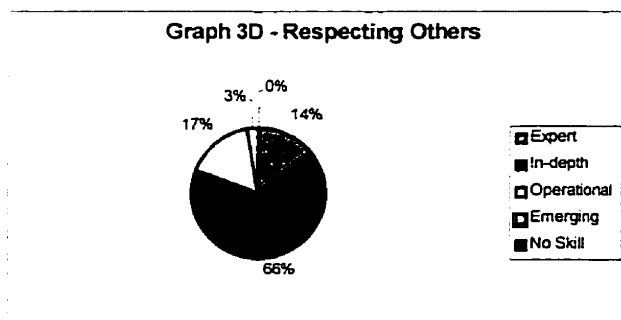
Expert	- 11%
In-depth	- 53%
Operational	- 33%
Emerging	- 3%
No Skill	- 0%

Themes

- in today's changing work environment, the ability to resolve conflict is a necessary skill (11 respondents);

- have been placed in situations where conflict between different individuals/groups was evident and I managed to address the situation (5 respondents).

D) Respecting Others



Response by Percentage

Expert	- 14%
In-depth	- 66%
Operational	- 17%
Emerging	- 3%
No Skill	- 0%

Themes

- a team approach is very important to making things work and accepting varied opinions and points of view is part of that process (5 respondents);
- it is important to recognize the value of accepting different perspectives, allowing people to be heard (5 respondents).

D) Using Informational Technology

The fourth of the core skill categories is titled Using Informational Technology, under which eleven core skill sets have been identified. Using informational technology has been defined within the ACCESS*MB*CSC tool as: "Using computer software/application appropriate to the job function to ensure a high level

of efficiency in accomplishing work" (Civil Service Commission, 1998).

Table 11 lists the eleven skill sets within the core skill category of Using Informational Technology and lists the frequency of responses of the respondents in those skill areas.

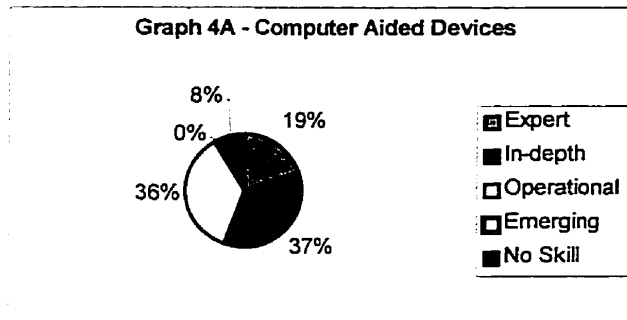
Table 11

Using Information Technology

Core Sub-Skill	Description	Expert	In-depth	Operationa	Emerging	No Skill
A) Using Computer Aided Devices	computer workstation hardware	7	13	13	0	3
B) Using Computer Aided Accounting Programs	one or more packages	1	2	5	11	17
C) Using Customized Computer Packages	to complete duties more effectively	2	4	11	5	14
D) Using Database Packages	one or more packages	1	9	14	8	4
E) Using Desktop Publishing	one or more packages	2	5	7	11	11
F) Using E-Mail/Intranet	using electronic mail as a communication tool	5	13	15	0	3
G) Using Presentation/Multimedia Packages	one or more packages	4	8	12	6	6
H) Using Spreadsheet Programs	one or more packages	2	10	11	7	6
I) Using the Internet	one or more package	3	12	11	4	6
J) Using Word-processing Packages	one or more packages	5	11	13	1	6
K) Web Page Design	designing/updating web pages	1	2	3	12	8

Frequency of Response By Skill With Theme(s)

A) Using Computer Aided Devices



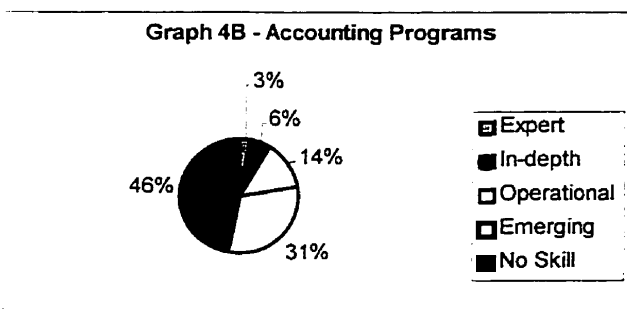
Response by Percentage

Expert	- 19%
In-depth	- 37%
Operational	- 36%
Emerging	- 0%
No Skill	- 8%

Theme

- computers are used on a daily basis to perform a wide range of functions (21 respondents).

B) Using Computerized Accounting Programs



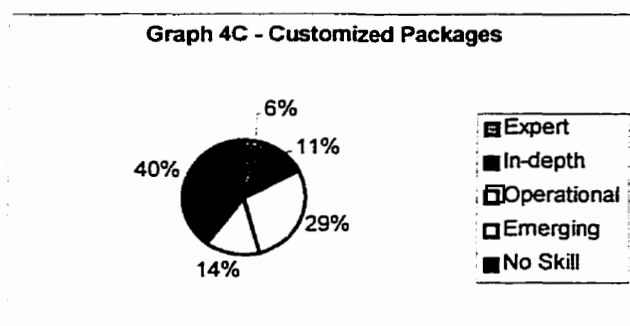
Response by Percentage

Expert	- 3%
In-depth	- 6%
Operational	- 14%
Emerging	- 31%
No Skill	- 46%

Theme

- No theme evident, individual users had specific examples of using accounting software applications for personal use (0 respondents).

C) Using Customized Computer Applications

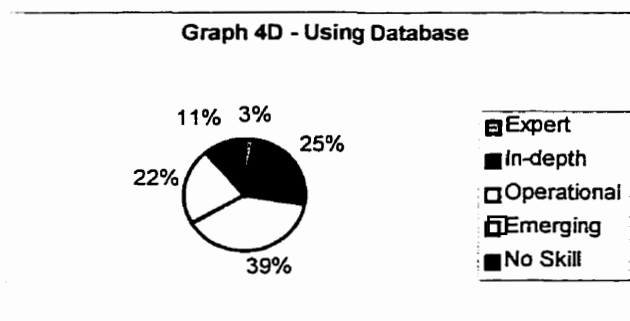
Response by Percentage

Expert	- 6%
In-depth	- 11%
Operational	- 29%
Emerging	- 14%
No Skill	- 40%

Theme

- possess a technical background in computers with use of spreadsheet and database applications (6 respondents).

D) Using Database Packages

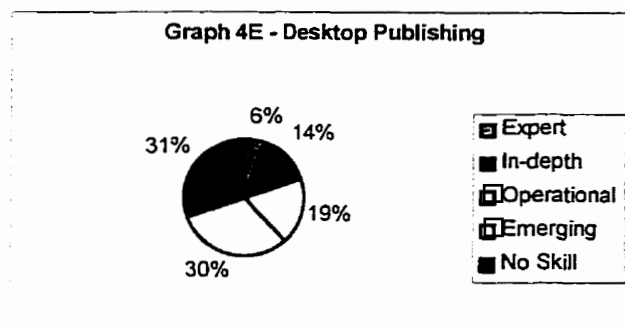
Response by Percentage

Expert	- 3%
In-depth	- 25%
Operational	- 39%
Emerging	- 22%
No Skill	- 11%

Theme

- have extensive experience in the use of databases, which has included creating databases for specific projects (10 respondents).

E) Using Desktop Publishing Packages

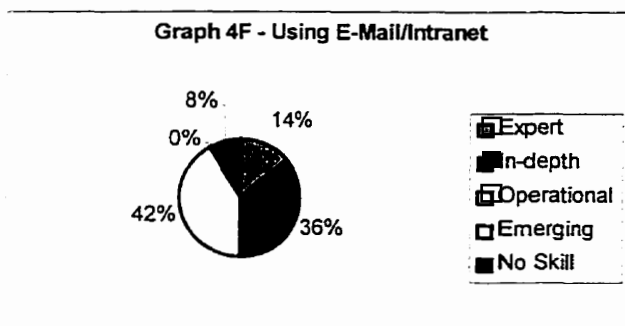
Response by Percentage

Expert	- 6%
In-depth	- 14%
Operational	- 19%
Emerging	- 30%
No Skill	- 31%

Theme

- used desktop publishing to create newsletters, presentation and other print material (6 respondents).

F) Using E-Mail/Intranet

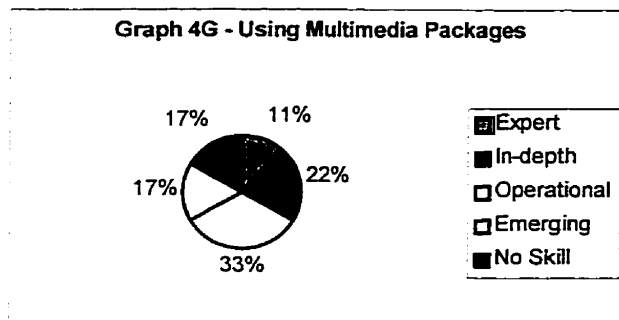
Response by Percentage

Expert	- 14%
In-depth	- 36%
Operational	- 42%
Emerging	- 0%
No Skill	- 8%

Theme

- use e-mail on a daily basis, both at home and work (18 respondents).

G) Using Presentation/Multimedia Packages

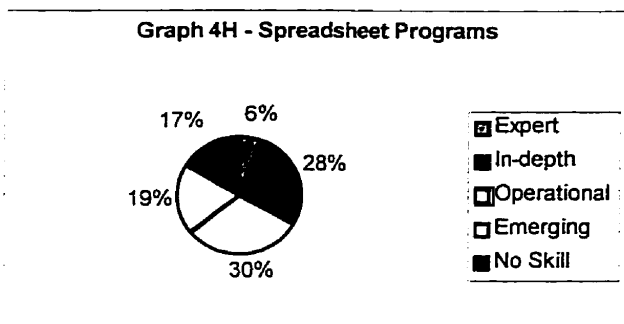
Response by Percentage

Expert	- 11%
In-depth	- 22%
Operational	- 33%
Emerging	- 17%
No Skill	- 17%

Theme

- used PowerPoint to create presentations (9 respondents).

H) Using Spreadsheet Packages

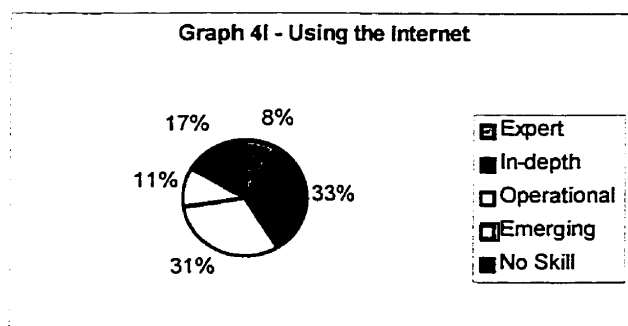
Response by Percentage

Expert	- 6%
In-depth	- 28%
Operational	- 30%
Emerging	- 19%
No Skill	- 17%

Theme

- extensive use of spreadsheets to create a wide range of reports (12 respondents).

I) Using the Internet

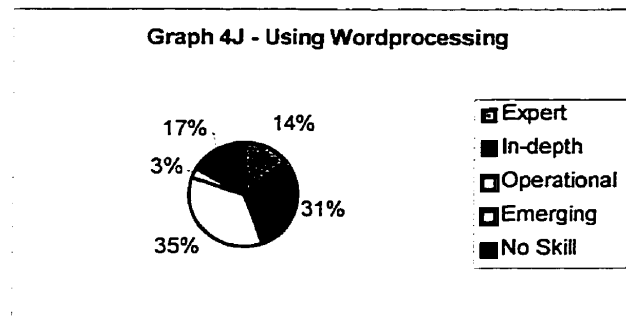
Response by Percentage

Expert	- 8%
In-depth	- 33%
Operational	- 31%
Emerging	- 11%
No Skill	- 17%

Theme

- use Internet on a regular basis, both at home and at work (17 respondents).

J) Using Wordprocessing Packages

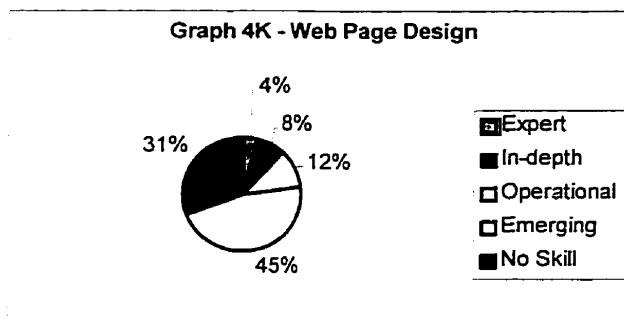
Response by Percentage

Expert	- 14%
In-depth	- 31%
Operational	- 35%
Emerging	- 3%
No Skill	- 17%

Themes

- used on a daily basis to create letters, memos, reports and tables (17 respondents);
- have taught the use of word processing packages (4 respondents).

K) Web Page Design

Response by Percentage

Expert	- 4%
In-depth	- 8%
Operational	- 12%
Emerging	- 45%
No Skill	- 31%

Theme

- have created web pages in the past (5 respondents).

E) Thinking Skills

The fifth of the core skill categories is titled Thinking Skills, under which nine core skill sets have been identified. Thinking skills has been defined within the ACCESS*MB*CSC tool as: "Uses cognitive

skills to think critically, understand, assess and solve problems" (Civil Service Commission, 1998).

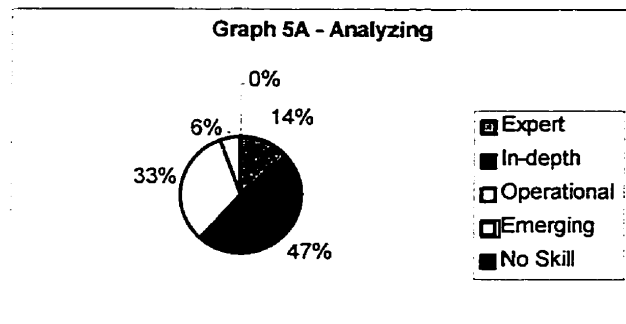
Table 12 lists the nine skill sets within the core skill category of Thinking Skills and lists the frequency of responses of the respondents in those skill areas.

Table 12
Thinking Skills

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Analyzing	organizing elements of a situation, taking onto account all factors	5	17	12	2	0
B) Applying Legislation	legislation, regulations, statutes, policies, etc	4	11	13	3	5
C) Applying Training/ Development	applying new knowledge, skills, abilities, etc	4	14	16	1	1
D) Decision Making	reaching sound and timely decisions	4	16	14	0	2
E) Evaluating	weighing the significance of several inputs	1	15	15	1	4
F) Interpreting	understanding the meaning of a situation, concept or problem	4	13	16	2	0
G) Planning	participate in establishing the framework and processes for strategic planning	5	13	9	6	3
H) Problem Solving	diagnosing situation, identify the cause and offer solutions	7	9	9	1	10
I) Research	research written material, conduct interviews, etc	7	10	6	1	12

Frequency of Response By Skill With Theme(s)

A) Analyzing



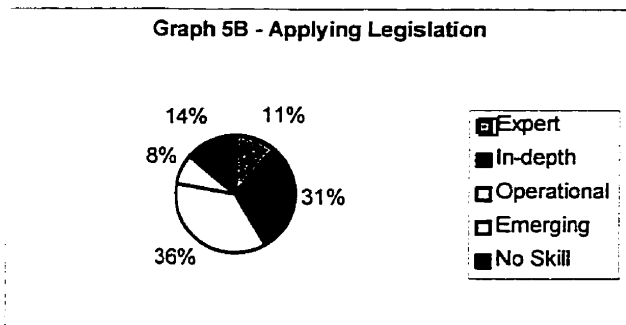
Response by Percentage

Expert	- 14%
In-depth	- 47%
Operational	- 33%
Emerging	- 6%
No Skill	- 0%

Themes

- responsible for the analysis of reports, research, program data and program policies (9 respondents);
- regularly analyze the entire situation, providing recommendations on actions that should be taken (7 respondents).

B) Applying Legislation



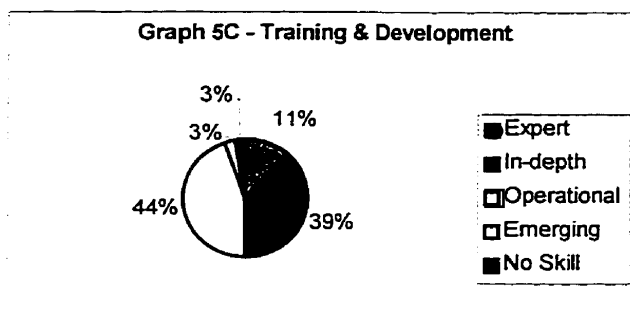
Response by Percentage

Expert	- 11%
In-depth	- 31%
Operational	- 36%
Emerging	- 8%
No Skill	- 14%

Theme

- involved in the analysis of problems and/or projects where the accurate interpretation and application of existing legislation is required (10 respondents).

C) Applying Training/Development

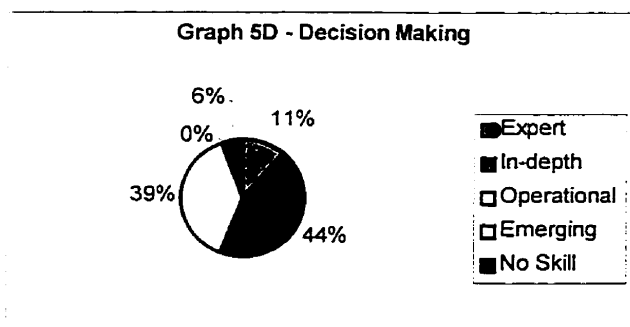
Response by Percentage

Expert	- 11%
In-depth	- 39%
Operational	- 44%
Emerging	- 3%
No Skill	- 3%

Themes

- regularly attend training/education sessions and apply what was learnt to my work situation (10 respondents);
- have participated in part time and workshop learning as a way of self-improvement (7 respondents).

D) Decision Making

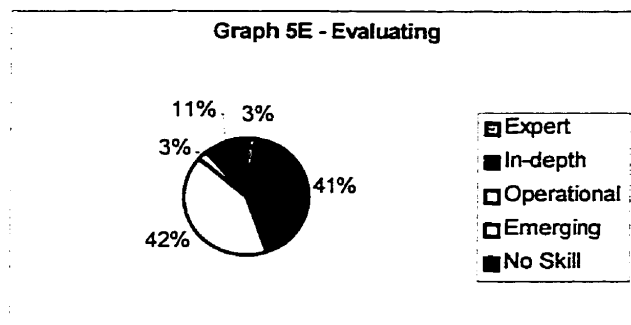
Response by Percentage

Expert	- 11%
In-depth	- 44%
Operational	- 39%
Emerging	- 0%
No Skill	- 6%

Themes

- decision making is of my current position (8 respondents);
- my efforts support the decision making process within Manitoba Health (7 respondents).

E) Evaluating

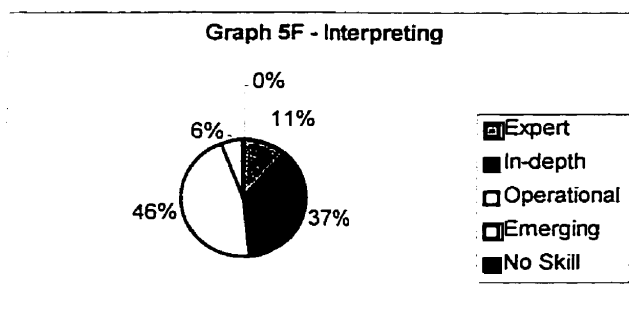
Response by Percentage

Expert	- 3%
In-depth	- 41%
Operational	- 42%
Emerging	- 3%
No Skill	- 11%

Themes

- have extensive experience with evaluating program proposals and initiatives (6 respondents);
- involved in standards development and outcome measurement (4 respondents).

F) Interpreting

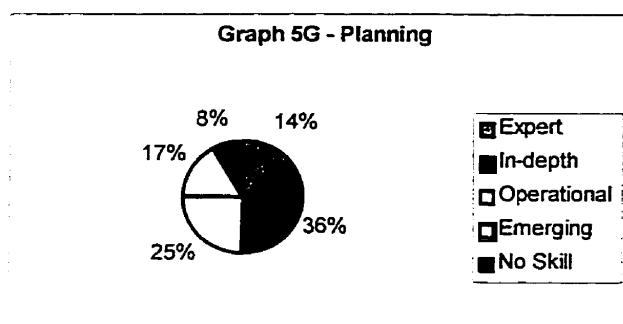
Response by Percentage

Expert	- 11%
In-depth	- 37%
Operational	- 46%
Emerging	- 6%
No Skill	- 0%

Theme

- have provided interpretation of policies and/or legislation as it related to specific situations (12 respondents).

G) Planning

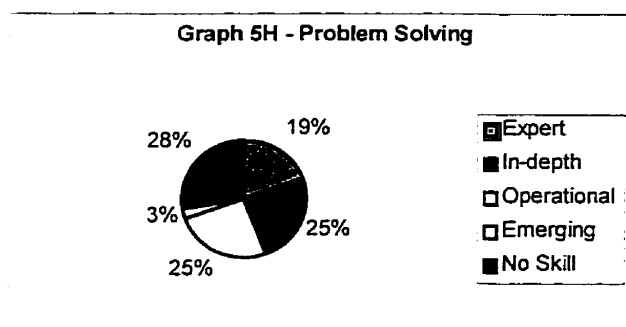
Response by Percentage

Expert	- 14%
In-depth	- 36%
Operational	- 25%
Emerging	- 17%
No Skill	- 8%

Theme

- have been involved in or lead various strategic, program and/or evaluation planning sessions (16 respondents).

H) Problem Solving

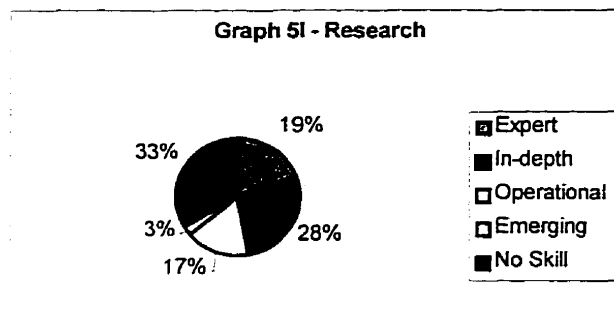
Response by Percentage

Expert	- 19%
In-depth	- 25%
Operational	- 25%
Emerging	- 3%
No Skill	- 28%

Theme

- in my present position, I am often expected to problem solve a number of often complex issues (12 respondents).

I) Research

Response by Percentage

Expert	- 19%
In-depth	- 28%
Operational	- 17%
Emerging	- 3%
No Skill	- 33%

Themes

- developed my research skills during the pursuit of my post-secondary education (5 respondents);
- my current position is research related and I am required to research a number of topics areas through a wide range of methodology (11 respondents).

F) Leadership Skills

The sixth core skill category is titled Leadership Skills, under which ten core skill sets have been identified. Leadership skills has been defined within the ACCESS*MB*CSC tool as:

Creates vision in the organization by fostering innovation, motivation, initiative, quality service, and adherence to core values, such as diversity, integrity and accountability. See the "big picture" by recognizing external influences, current and future, which impact on the

organization/client/self (Civil Service Commission, 1998).

Table 13 lists the ten skill sets within the core skill category of Thinking Skills and lists the frequency of responses of the respondents in those skill areas.

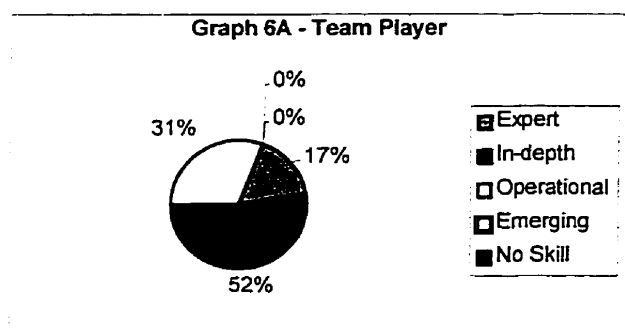
Table 13

Leadership Skills

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Being a Team Player	working in a team environment	6	19	11	0	0
B) Creating Vision	translating vision into measurable value added goals/objectives	5	12	15	3	1
D) Displaying Initiative	demonstrating willingness to take on new challenges	9	21	6	0	0
E) Encouraging Innovation	for self and others	4	14	14	2	2
F) Ensuring Clear Values	ensures workplace values	3	16	14	2	1
F) Leading by Example	setting examples for other to follow	2	23	10	1	0
G) Motivating Others	increasing the productivity of others, creating positive attitude	2	20	10	4	0
H) Taking Calculated Risks	pursuing new opportunities	3	13	7	4	9
I) Understanding and Supporting Corporate Culture	understanding priorities, mission, etc	3	11	11	3	8
J) Valuing Diversity	respects workplace diversity	3	10	10	3	10

Frequency of Response By Skill With Theme(s)

A) Being a Team Player



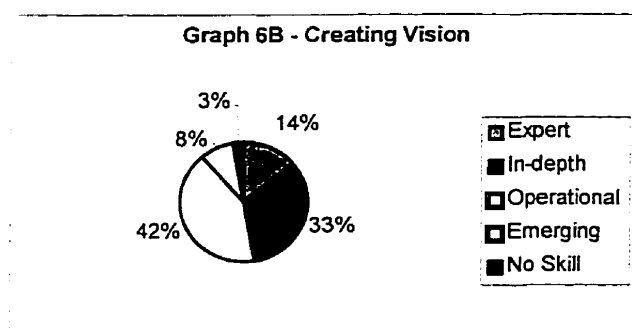
Response by Percentage

Expert	- 17%
In-depth	- 52%
Operational	- 31%
Emerging	- 0%
No Skill	- 0%

Themes

- Manitoba Health is moving more towards team approaches to project management (7 respondents);
- have worked extensively in a team environment, which has become a workload management strategy (17 respondents).

B) Creating Vision



Response by Percentage

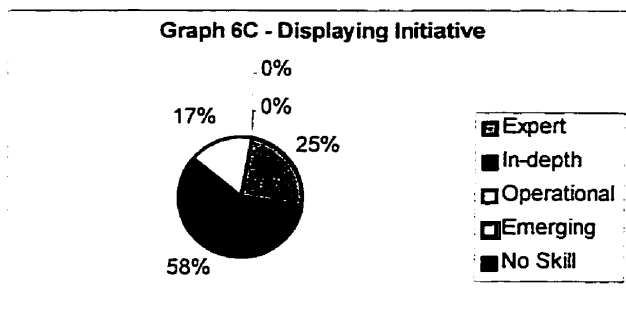
Expert	- 14%
In-depth	- 33%
Operational	- 42%
Emerging	- 8%
No Skill	- 3%

Themes

- participated in visioning exercises to determine the future direction of the organization (7 respondents);

- linked vision of the organization to its mission, goals and objectives through program development (8 respondents).

C) Displaying Initiative



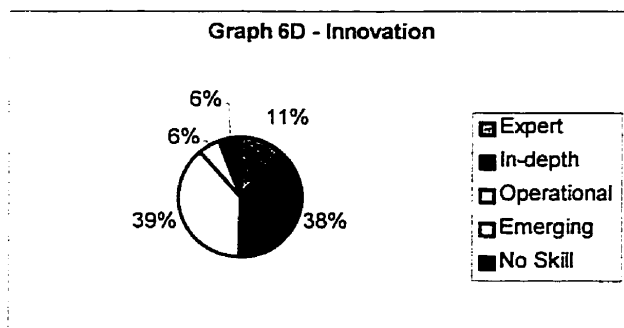
Response by Percentage

Expert	- 25%
In-depth	- 58%
Operational	- 17%
Emerging	- 0%
No Skill	- 0%

Themes

- constantly looking for new and different ways of improving work processes (8 respondents);
- have taken on additional responsibilities through special projects (9 respondents);
- have implemented new and successful initiatives (7 respondents).

D) Encouraging Innovation



Response by Percentage

Expert	- 11%
In-depth	- 38%
Operational	- 39%
Emerging	- 6%
No Skill	- 6%

Themes

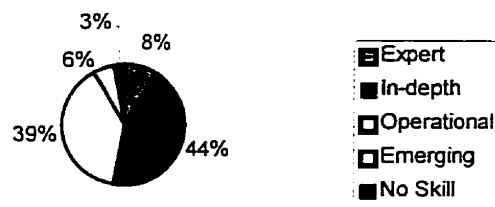
- consistently challenge staff/colleagues to make improvements in existing programs or services, or

create new approaches or options (11 respondents);

- constantly challenge the status quo, fostering change and innovative thinking (6 respondents).

E) Ensuring Clear Values

Graph 6E - Clear Values



Response by Percentage

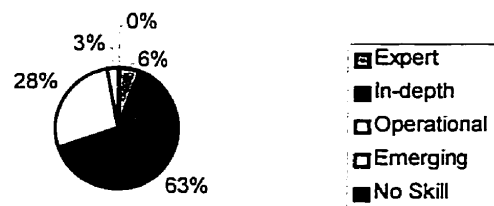
Expert	- 8%
In-depth	- 44%
Operational	- 39%
Emerging	- 6%
No Skill	- 3%

Theme

- recognize the important of workplace values and encourage, through example, adherence to these values by all staff (17 respondents).

F) Leading by Example

Graph 6F - Leading By Example



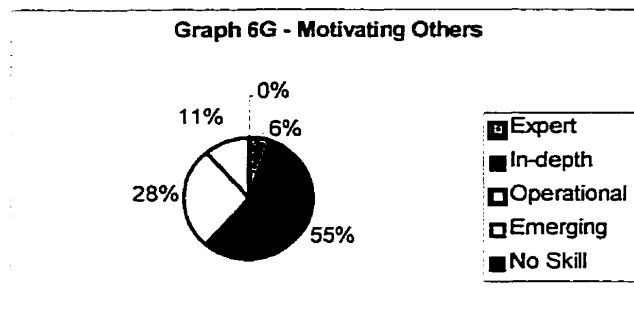
Response by Percentage

Expert	- 6%
In-depth	- 63%
Operational	- 28%
Emerging	- 3%
No Skill	- 0%

Theme

- role modeling is important within the workplace, and every attempt is made to demonstrate above average work behaviors and ethics (19 respondents).

G) Motivating Others

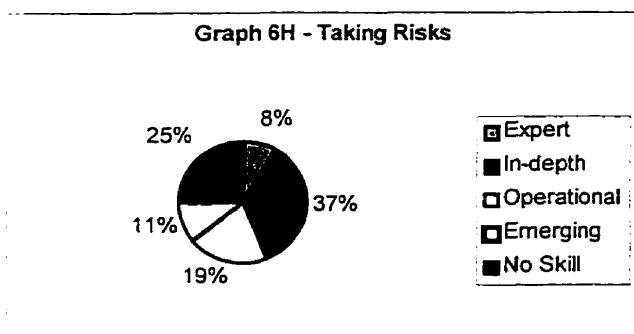
Response by Percentage

Expert	- 6%
In-depth	- 55%
Operational	- 28%
Emerging	- 11%
No Skill	- 0%

Themes

- ensure staff receive positive feedback and reinforcement for a job well done (6 respondents);
- create a positive work environment through the demonstration of positive approaches to all aspects of work (14 respondents).

H) Taking Risks

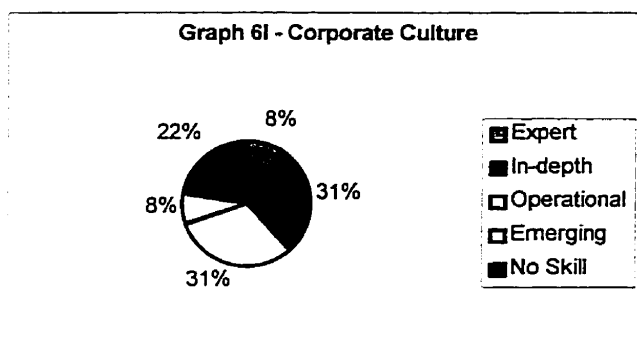
Response by Percentage

Expert	- 8%
In-depth	- 37%
Operational	- 19%
Emerging	- 11%
No Skill	- 25%

Theme

- willing to take calculated risks to improve work processes or to move new concept along to acceptance and implementation (15 respondents).

I) Understanding & Supporting Corporate Culture

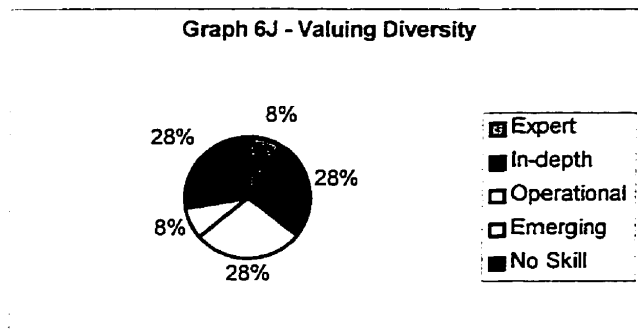
Response by Percentage

Expert	- 8%
In-depth	- 31%
Operational	- 31%
Emerging	- 8%
No Skill	- 22%

Theme

- an understanding of the department's corporate culture as it translates to its goals, objectives and policies is important to daily operations and how we interact with our clients (12 respondents).

J) Valuing Diversity

Response by Percentage

Expert	- 8%
In-depth	- 28%
Operational	- 28%
Emerging	- 8%
No Skill	- 28%

Theme

- value the opinions and different viewpoints from both colleagues and the various other client groups Health interacts with that represent a broad range of ethnic and cultural backgrounds (11 respondents).

G) Self Management

The last core skill category is titled Self Management, under which five core skill sets have been identified. Self Management has been defined within the ACCESS*MB*CSC tool as: "Identifies means to improve one's own performance, resulting in continuous learning and development of oneself" (Civil Service Commission, 1998).

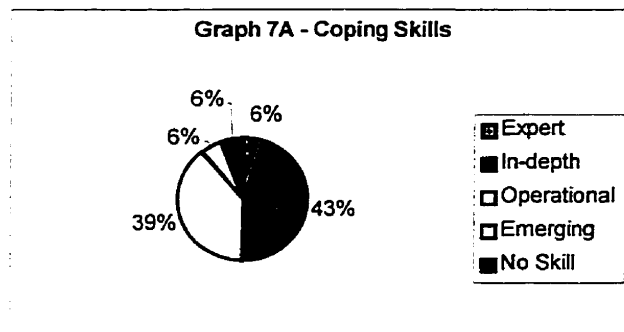
Table 14 lists the five skill sets within the core skill category of Self Management and lists the frequency of responses of the respondents in those skill areas.

Table 14
Self Management

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Demonstrating Coping Skills	developing/applying coping skills to stressful events	2	16	14	2	2
B) Demonstrating Flexibility	changing styles, adopt new approaches	4	19	13	0	0
C) Demonstrating Integrity	making actions match words	7	13	14	1	1
D) Demonstrating Motivation	personal motivation to do your best	6	18	11	0	1
E) Life Long Learning	using a variety of sources to obtain/maintain knowledge/skills	5	20	7	2	2

Frequency of Response By Skill With Theme(s)

A) Demonstrating Coping Skills



Response by Percentage

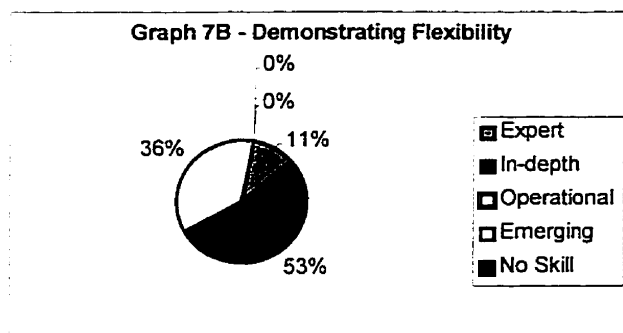
Expert	- 6%
In-depth	- 43%
Operational	- 39%
Emerging	- 6%
No Skill	- 6%

Theme

- the changing work environment within Manitoba

Health has created increasing degree of stress which require different coping mechanisms which have included: exercise, humour in the workplace, taking time off, and participating in non-work related activities (17 respondents).

B) Demonstrating Flexibility



Response by Percentage

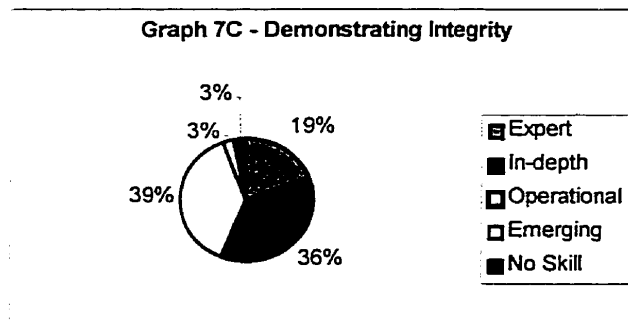
Expert	- 11%
In-depth	- 53%
Operational	- 28%
Emerging	- 36%
No Skill	- 0%

Themes

- given the changes Manitoba Health is undergoing, being flexible is necessary to remain effective (6 respondents);

- changing expectations regarding roles and responsibilities requires all to take a flexible approach to work (16 respondents).

C) Demonstrating Integrity



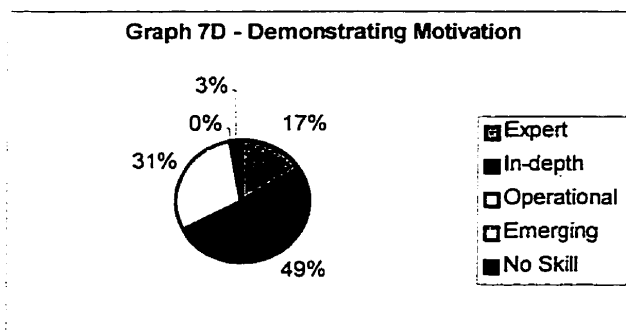
Response by Percentage

Expert	- 11%
In-depth	- 53%
Operational	- 28%
Emerging	- 36%
No Skill	- 0%

Themes

- consistently demonstrate excellent work ethics, ensuring a consistent level of high quality work product (12 respondents);
- strive to meet or exceed performance expectations in terms of quality and meeting deadlines (6 respondents).

D) Demonstrating Motivation



Response by Percentage

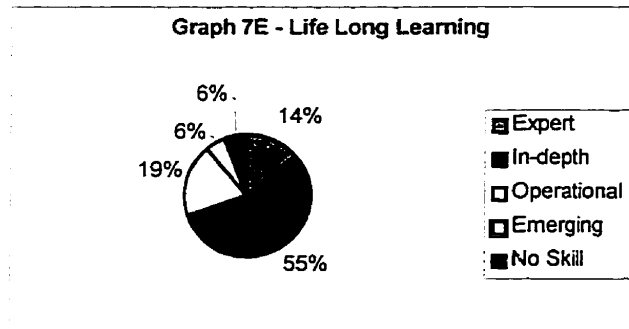
Expert	- 17%
In-depth	- 49%
Operational	- 31%
Emerging	- 0%
No Skill	- 3%

Themes

- highly motivated, always willing to take on new tasks or challenges (9 respondents);

- set high standards of achievement and pursue them aggressively (12 respondents).

E) Life Long Learning



Response by Percentage

Expert	- 14%
In-depth	- 55%
Operational	- 19%
Emerging	- 6%
No Skill	- 6%

Themes

- seek out new learning opportunities on a regular basis to improve my skill base in a number of different areas (8 respondents);
- have taken and will continue to enroll in workshops, seminars, courses and university programs outside of work related topics (8 respondents);
- focus of skill development is in the area of informational technology, with emphasis on computer technology (6 respondents).

Summary

Section B addressed research question three in answering what skill sets Manitoba Health staff currently possesses establishing the "what is". In analyzing the data it became evident that the staff

possess some degree of skill or competency in all core competency categories and their respective skill sets. Based on the results of the staff respondents' self-assessment ratings, the core competency areas listed in order of greatest staff strengths are: Interpersonal Skills, Communications, Self Management, Managing for Results, Leadership Skills, Thinking Skills and Using Informational Technology. The following section compares the "what is" against the "what should be" to address research question four regarding gap analysis.

Section C - Research Question Four

The final research question deal specifically with determining if a gap in skill sets actually exists between "what is", otherwise known as the current state, and the "what should be" or the desired state. In order to clearly demonstrate if a gap actually exists the data collected from the staff respondents, which represented the "what is" was compared directly to the data collected from the executive management, which represented the "what should be".

Analysis of the data that resulted from the interviews of the executive management had revealed what they thought the future role of Manitoba Health

would be, as well as what competencies or skill sets the staff would need to possess. Specifically, the future role of Manitoba Health would focus increasingly on legislation, policy, standards, program development, funding/purchasing services, and monitoring and evaluation. This direction in future role is consistent with both Kettl (1991) and the report generated by the Ontario Government (1995) cited earlier in the paper (see pp. 9-10). The corresponding skill sets required within the staff would be increased capacity in analysis, evaluation, strategic planning, policy management, issues management and informational technology. These required competencies align to those skill sets contained with the *ACCESS*MB*CSC* skills analysis tool which were rated by each of the executive management.

Within Section A, the results of the rating exercise carried out by the executive management were illustrated in table form. From this, it became evident that while inter-rating comparison and prioritization within each core competency category was possible and subsequently done for this section, virtually all of the core competency categories with their respective skill sets held importance to the

executive management. Within Section B, clear patterns of the Manitoba Health's staff strengths and deficits within each core competency also became evident.

Comparing the two sets of data revealed that gaps in current and desired skill sets actually exists in each of the core competency categories.

The next set of tables clearly illustrates where the skill set or competency gaps exist within Manitoba Health. The criteria applied to quantify the extent of the gap (see pp. 73-74) was:

- no gap - 76 to 100% combined response of "in-depth & expert";
- emerging gap - 51 to 75% combined response of "in-depth & expert";
- significant gap - 26 to 50% combined response of "in-depth & expert";
- absolute gap - 0 to 25% combined response of "in-depth & expert".

Table 15**Communication Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Informing	78%	None
Listening	83%	None
Writing	69%	Emerging
Speaking	69%	Emerging

Table 16**Managing for Results Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Managing People	55%	Emerging
Ensuring Quality/Quantity	53%	Emerging
Evaluating Results	58%	Emerging
Managing Time	53%	Emerging
Organizing	50%	Significant
Managing Projects	55%	Emerging
Managing IT	53%	Emerging
Managing Dollars	51%	Emerging
Business Skills	25%	Absolute

Table 17**Interpersonal Skills Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Customer Service	83%	None
Respecting Others	80%	None
Networking	67%	Emerging
Resolving Conflict	64%	Emerging

Table 18**Using Information Technology Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Using E-Mail/Intranet	50%	Significant
Using Customized Computer Packages	17%	Absolute
Using Computer Aided Devices	56%	Emerging
Using Computer Aided Accounting Programs	9%	Absolute
Using Database Packages	28%	Significant
Using Presentation/Multimedia Packages	33%	Significant
Using Spreadsheet Programs	34%	Significant
Using Desktop Publishing	20%	Absolute
Using the Internet	41%	Significant
Using Wordprocessing Packages	45%	Significant
Web Page Design	12%	Absolute

Table 19**Thinking Skills Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Problem Solving	44%	Significant
Analyzing	61%	Emerging
Decision Making	56%	Emerging
Evaluating	44%	Significant
Planning	50%	Significant
Applying Training/Development	50%	Significant
Interpreting	48%	Significant
Applying Legislation	42%	Significant
Research	47%	Significant

Table 20**Leadership Skills Gap Analysis**

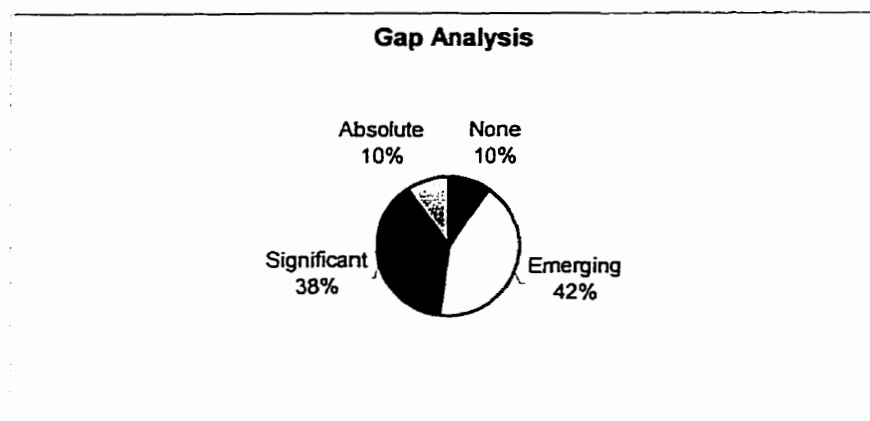
Skill Set (Ranked)	Response (by percent)	Gap Analysis
Motivating Others	61%	Emerging
Being a Team Player	69%	Emerging
Leading by Example	69%	Emerging
Creating Vision	47%	Significant
Displaying Initiative	83%	None
Valuing Diversity	36%	Significant
Encouraging Innovation	49%	Significant
Taking Calculated Risks	45%	Significant
Understanding and Supporting Corporate Culture	45%	Significant
Ensuring Clear Values	52%	Emerging

Table 21**Self Management Gap Analysis**

Skill Set (Ranked)	Response (by percent)	Gap Analysis
Demonstrating Coping Skills	49%	Significant
Demonstrating Flexibility	64%	Emerging
Demonstrating Integrity	64%	Emerging
Demonstrating Motivation	66%	Emerging
Life Long Learning	70%	Emerging

Summary

The final illustration within this chapter, Graph 15, provides a summative picture of the overall skill set or competency gap that exists within Manitoba Health by total number of individual skill sets contained within the core competency categories. Ninety percent of the responses provided by the staff respondents fell into the gap criteria categories of "emerging", "significant" and "absolute". Almost half or some 48% of the responses fell into the "significant" and "absolute" gap criteria categories. While this suggests that there are obvious skill sets deficits within Manitoba Health, it does not automatically mean that the staff is not skilled. These results, however, do support Kettl (1991) who argued that very different skill sets are required within government to manage contracted out programs as opposed to the delivery of programs (see pp. 9 - 10).

Graph 8**Gap Analysis Response by Total Skill Sets**

The final chapter will detail the conclusions that can be drawn from this research, as well as provide recommendations based on the identified issues.

Chapter 5

Conclusions and Recommendations

The purpose of this research was to determine what the desired or needed skill sets for the staff of Manitoba Health are, comparing those against the skill sets that currently exist. The research questions addressed were:

1. What is the current and future mandate (role and function) of Manitoba Health under its new organization structure?
2. What are the desired skill sets required of the staff of Manitoba Health in order for them to meet the stated mandate?
3. What skill sets does the staff of Manitoba Health currently possess?
4. Does a gap actually exist between the current skill sets possessed by the staff of Manitoba Health and the desired skill sets as identified by executive management?

Current and Future Mandate

Manitoba Health's overall mandate appears to have remained unchanged through the years. The mandate as identified through the executive management interviews

is to deliver the best health care system that Manitobans can afford. Clearly, this mandate has stood the test of time when compared to the Department of Health and Welfare's 1928 mandate of the promotion of health and welfare of the people of Manitoba (see p. 5), with the only apparent revision being the emphasis on affordability. So while it can be anticipated that this mandate will continue well into the future, how Manitoba Health goes about meeting their mandate has certainly changed.

Manitoba Health is an organization that has recently gone through and is likely to continue to undergo substantial change in the immediate future. Consistently identified by the executive management, the most significant change has been the transition from that of an organization that was involved in direct service delivery to that of an organization managing an alternate service delivery model. The alternate service delivery model has, for the most part, been in the form of the newly created regional health authorities. This change in service delivery has impacted directly on the roles and functions of the department and its staff. As identified in chapter 4, Manitoba Health now needs to shift its focus from

direct service delivery to that of indirect management roles such as legislation, policy, standards, contract management, program development, funding, and monitoring and evaluation. The staff has to move from being the "doers" of the system to that being the "assessors and analysts of the system".

Desired Skill Sets

The executive management clearly articulated the competencies or skill sets that they felt would be important to Manitoba Health. To them it would be critical to ensure that the organization develop staff capacity in the areas of analysis, evaluation, research, policy management, decision making, strategic planning, issues management and information technology. These skill sets or competencies were directly reflected within the core competency section of the ACCESS*MB*CSC skills analysis tool which the executive management had individually rated according to levels of importance.

The ACCESS*MB*CSC skills analysis tool identified seven core competency categories, with each category containing a number of skill sets. These core competency categories included: Communications,

Managing for Results, Interpersonal Skills, Using Information Technology, Thinking Skills, Leadership Skills, and Self Management. With the rating of the individual skill sets found within each core competency category, the relative ranking of these categories are:

1. Leadership Skills
2. Thinking Skills
3. Communications
4. Managing for Results
5. Self Management
6. Interpersonal Skills
7. Using Information Technology

Focusing on the individual skill sets, it is extremely interesting and relevant to note that only 6 of the 52 individual skills were rated as being as "not important" by one or more of the executive management. Further, all but one of these skills fell within the core competency category of Using Information Technology sets. The individual skill sets regrouped by importance according to the executive management team's responses are:

1. Motivating others, problem solving, informing, and demonstrating integrity.

2. Being a team player, creating vision, displaying integrity, leading by example, valuing diversity, analyzing, decision making, evaluating, listening, writing, and managing people.
3. Encouraging innovation, taking calculated risks, understanding and supporting corporate culture, interpreting, ensuring quality/quantity, evaluating results, managing time, organizing, lifelong learning, customer service, respecting others, and using e-mail.
4. Applying training & development, planning, speaking, managing projects, demonstrating coping skills, demonstrating motivation, and using customized computer packages.
5. Ensuring clear values, applying legislation, managing information technology, demonstrating flexibility, networking, resolving conflict, using computer aided devices, using presentation & multimedia packages, and using spreadsheet programs.
6. Demonstrating business skills, managing dollars, using computer and aided accounting programs.

7. Research, using database packages, using desktop publishing, using the Internet, and web page design.

Current Skill Sets

The staff of Manitoba Health, through the completion of selected sections of the *ACCESS*MB*CSC* skills analysis tool, have demonstrated that the desired skills as identified by the executive management are resident within the department. However, what is strongly suggested based on the data generated by the staff respondents is that an insufficient skill base does exist within the department of those skill sets or competencies identified as being important to the organization as listed above. There is also a very likely possibility that those individuals who do possess the desired skill sets have not been identified and the department has not taken advantage of these individuals as an internal resource.

Based on the data collected from the staff respondents and the rating of the individual skill sets found within each core competency category, the relative ranking of these are:

1. Interpersonal Skills
2. Communications
3. Self Management
4. Managing for Results
5. Leadership Skills
6. Thinking Skills
7. Using Information Technology

The individual skills currently possessed by the staff within Manitoba Health grouped by rated response ranging from most developed to least developed are:

1. Customer service, respecting others, informing, listening, and displaying initiative.
2. Networking, resolving conflict, using computer aided devices, writing, speaking, managing people, ensuring quality/quantity, evaluating results, managing time, managing projects, managing information technology, managing dollars, analyzing, decision making, motivating others, being a team player, leading by example, ensuring clear values, demonstrating flexibility, demonstrating integrity, demonstrating motivation, and lifelong learning.
3. Organizing, problem solving, evaluating, planning, applying training & development, interpreting,

applying legislation, research, creating vision, valuing diversity, encouraging innovation, taking calculated risks, understanding & supporting corporate culture and demonstrating coping skills.

4. Using customized computer packages, using desktop publishing, web page design, and demonstrating business skills.

Does a Gap Exist

Following the analysis of the data collected from the two target population involved in this research, it is evident that a skill or competency gap does exist between what the executive management have identified as the desired skill sets and the current skill sets possessed by the staff. With specific reference to Graph 15 (p. 135), of the 52 skills or competencies rated by both groups, measurable gaps exist in 46 or 90% of the competencies. The extent of the gaps range from emerging (42%) to significant (38%) to absolute (10%), although the true significance of the skills gap can be better understood by looking at the core competency category level.

Table 22 contains the seven core competency categories ranked by importance based on the analysis

of the data generated by the executive management and by skill set development based on the analysis of the data generated by the staff respondents. From the information contained within this table the significance of the skills gap becomes more evident.

Table 22 - Ranked Core Competency Categories

Executive Management	Staff Respondents
1) Leadership Skills	1) Interpersonal Skills
2) Thinking Skills	2) Communications
3) Communications	3) Self Management
4) Managing for Results	4) Managing for Results
5) Self Management	5) Leadership Skills
6) Interpersonal Skills	6) Thinking Skills
7) Using Information Technology	7) Using Information Technology

Based on this information, the executive management ranked the core competency categories of Leadership Skills and Thinking Skills, and their respective individual skill sets, as the top two desired competency categories. These same two categories ranked fifth and sixth in skill set bench strength on the staff respondent side, with a 40% emerging and 50% significant gap response rate for Leadership Skills and a 22% emerging and a 78%

significant gap response rate for Thinking Skills. In comparison, the core competency categories of Self Management and Interpersonal Skills were ranked fifth and sixth respectively by the executive management, whereas on the staff respondent side these same core competency categories were listed first and third respectively. Interpersonal Skills had a gap response rate of 50% none and 50% emerging, while Self Management had a gap response rate of 80% emerging and 20% significant.

The conclusion that can be made through this comparison is that while measurable gaps exist in all four of the core competency categories, the skill set gaps that exist in Leadership and Thinking Skills is of more significance than the gaps that exist in Self Management and Interpersonal Skills. While prioritization for the purpose of developing strategies to address the identified skill set gaps is beyond the scope of this research, it would be an important step to consider if any corrective action is initiated as a result of this study.

Other Findings

This study represents the first time that the *ACCESS*MB*CSC* skills analysis tool developed by Manitoba's Civil Service Commission has been used by a randomly selected population who brought with them an unknown degree of computer literacy. The design of the tool proved to be extremely functional and was easily followed by all participants once the researcher, who facilitated the data collection sessions, took each group through its first section. The tool also allowed each participant to print out his or her own self assessment results immediately upon completion. Many of the respondents commented on the potential usefulness of the report for individual career planning.

On the less positive side, approximately half of the participants voiced concerns about the length of time it took to complete the self assessment. The majority of the respondents required the full three hours scheduled to finish the assessment, while two individuals had to attend a second session to complete their assessment. Also, many participants complained about feeling physically tired by the end of the session and had difficulty concentrating during the

final hour. These concerns will have implications for future users of the *ACCESS*MB*CSC* skills analysis tool. Issues of scheduling and costs of staff time required to complete the assessment tool are both significant factors.

Conclusion

The findings from this study provide Manitoba Health executive management with a clear picture of the department's current capabilities in terms of those skill sets or competencies identified as being critical to the organization's overall short term and long term success. The results can be used by the executive management to develop strategies to address the existing skill set gaps whether it be through the reassignment of staff and/or training and development or the hiring of new staff.

For the staff participants of the study, each now possess a skill inventory that provides them with an individualized report of their overall bench strengths in each of the seven core competency categories. This information can be used to aid in the development of individualized training and development plan or it can be shared with their immediate supervisor for

consideration of future opportunities within the department. For the entire Manitoba Health staff, the findings provide a clear statement of the department's mandate (see p. 81), as well as a clearer understanding of the future direction of the department (see pp. 82 - 83). They are now also aware of the skill sets or competencies that the executive management has identified as being important to the department's evolving roles and functions (see p. 138 - 140).

Finally, this study should prove useful to other government departments which have recently gone or who are currently undergoing substantial change, which is placing new demands on their existing staff. This would hold especially true for the other departments of health in Canada, all of whom are at different stages in transitioning away from direct service delivery to an alternate service delivery model.

Recommendations

The following recommendations are a direct result of the findings of this study and are for the consideration of the executive management for Manitoba Health:

1. That the executive management develop and implement a communication strategy aimed at informing all staff of Manitoba Health's current mandate, highlighting the evolving nature of its roles and functions;
2. That a change management strategy be developed, with staff input, and then widely distributed to ensure a broad understanding of the direction Manitoba Health is undertaking;
3. That a departmental-wide staff training and development strategy be developed and implemented to ensure that the goals and objectives of Manitoba Health are achieved through a skilled staff compliment. Part of this strategy would be to clearly articulate the desired skill sets being sought. Any skill set that has an "emerging" gap should be viewed as a development opportunity where existing staff, through a purposeful plan of action, can be trained to meet the changing or new organizational demands;
4. That the *ACCESS*MB*CSC* skills analysis (inventory) tool be implemented department-wide for the development and maintenance of a Manitoba Health skills inventory database;

5. That position/project matching be implemented where appropriately skilled and experienced staff are given different opportunities within Manitoba Health to the mutual benefit of both parties;
6. That career planning workshops be developed and implemented to support the ongoing and future developmental needs of all staff, with purposeful linkages to a Manitoba Health succession planning strategy.

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APPENDIX A

Interview Guide

Executive Management, MB Health

Interview # _____

Section A: Role(s) & Function(s)

- 1) Organizational change seems to be have become matter of fact within Manitoba Health. What do you feel have been the most significant changes of Manitoba Health?

Prompts:

- a) Over the last 5 years?
- b) Over the last 2 years?
- c) Over the last year?
- d) Over the last 6 months?

- 2) What has been the impact of these changes on the mandate of Manitoba Health?

Prompts:

- a) Agreement on mandate by executive management?
- b) Is the current mandate well understood by staff?
- c) By the regional health authorities?

- 3) What is the current role(s) and function(s) of Manitoba Health?

Prompts:

How does this compare to:

- a) 5 years ago?
- b) 2 years ago?
- c) 1 year ago?

- 4) How well do you believe that this current role(s) and function(s) is understood by the individuals who make up or who are served by Manitoba Health?

Prompts:

- a) Executive management?
- b) Staff?

Section A: Role(s) & Function(s)

5) What do you believe to be the current organizational needs of Manitoba Health?

Prompts:

- a) Structure?
- b) Functional units?
- c) Staffing?
- d) Resources?
- e) Prioritization?

6) What challenges do you feel lie ahead of Manitoba Health?

Prompts:

- a) Mandate?
- b) Role(s) and function(s)?
- c) Further needs?
- d) Prioritization?

7) How important is it to have an effective change management strategy in place and do you believe that Manitoba Health has a change management strategy in place?

Prompts:

- a) Impact on employees?
- b) Resources?
- c) Training & development?

8) Concluding remarks within this section?

Section B: Required Skill Sets

1) What type of impact has the organizational changes had upon staff responsibilities?

Prompts:

- a) Director/managerial level?
- b) Supervisory level?
- c) Professional level?
- d) Administrative level?

2) What new demands has this placed on staff?

Prompts:

- a) How has this differed from:
 - i) 5 years ago
 - ii) 2 years ago
- b) Has staff been meeting these demands?
- c) Meeting current organizational needs?

3) On the sheet I have handed you, the CSC has identified a number of core competencies that all civil servants need to possess to advance government into the next decade.

Can you comment on this list?

Prompts:

- a) Can you rank them?
- b) Any additions?

Section B: Required Skill Sets

- 4) Within these core competencies there are a great variety of skills that civil servants need to possess. What do you feel the required skills are?

Prompts:

- a) To meet current organizational needs?
- b) Future organization needs?
- c) Critical Vs nice to have?
- d) Top 3 skills
- e) Current strengths?
- f) Areas for development?

- 5) In your view, what would a training & development plan for staff consist of and to what degree would you support such a plan?

Prompts:

- a) In-house Vs external?
- b) At all levels?
- c) Support time off?
- d) Funding?

- 6) Concluding remarks within this section?

- 7) Concluding remarks for the interview?

APPENDIX B

Core Skill Sets Rating Sheet

1) *Communication*

- a) **Informing:** passes information along on a timely basis.
- b) **Listening:** actively listening to understand.
- c) **Speaking:** speaking in a concise and clear manner to a variety of audiences.
- d) **Informing:** writing in a concise and clear manner.

Not Important

Somewhat Important

Very Important

2) *Managing for Results*

- a) **Demonstrating Business Skills:** thinking/acting in an entrepreneurial manner.
- b) **Ensuring Quality/Quantity:** balances quality of results with quantity.
- c) **Evaluating Results:** monitoring performance and results.
- d) **Managing Dollars:** using budget dollars to achieve planned results.
- e) **Managing Information Technology:** uses IT appropriately, effectively, efficiently.
- f) **Managing People:** fosters high performance, manages resources.
- g) **Managing Projects:** administration of a program involving multiple resources.
- h) **Managing Time:** plans and organizes tasks in a logical/concise manner.
- i) **Organizing:** schedules and coordinates work, prioritizes, meets objectives

3) Interpersonal Skills

- | | Not Important | Somewhat Important | Very Important |
|---|---------------|--------------------|----------------|
| a) Customer Service: committing to help or | | | |
| b) serve others (internal/external customers). | _____ | _____ | _____ |
| c) Networking: builds and maintains broad | | | |
| informal network of contacts. | _____ | _____ | _____ |
| d) Resolving Conflict: bringing conflict | | | |
| into the open and using it productively. | _____ | _____ | _____ |
| e) Respecting Others: develops and maintains | | | |
| cooperative relationships. | _____ | _____ | _____ |

4) Using Information Technology

- | | | | |
|--|-------|-------|-------|
| a) Using Computer Aided Devices: computer | | | |
| workstation hardware. | _____ | _____ | _____ |
| b) Using Computer Aided Accounting Programs: | | | |
| one or more packages. | _____ | _____ | _____ |
| c) Using Customized Computer Packages: to | | | |
| complete duties more effectively. | _____ | _____ | _____ |
| d) Using Database Packages: one or more | | | |
| packages. | _____ | _____ | _____ |
| e) Using Desktop Publishing: one or more | | | |
| packages. | _____ | _____ | _____ |
| f) Using E-Mail/Intranet: using electronic mail | | | |
| as a communication tool. | _____ | _____ | _____ |
| g) Using Presentation/Multimedia Packages: one | | | |
| or more packages. | _____ | _____ | _____ |
| h) Using Spreadsheet Programs: one or more | | | |
| packages. | _____ | _____ | _____ |
| i) Using the Internet: one or more packages. | | | |
| j) Using Wordprocessing Packages: one or more | | | |
| packages. | _____ | _____ | _____ |
| k) Web Page Design: designing/updating web | | | |
| pages. | _____ | _____ | _____ |

5) Thinking Skills

- | | Not Important | Somewhat Important | Very Important |
|---|---------------|--------------------|----------------|
| a) Analyzing: organizing elements of a situation, taking onto account all factors. | _____ | _____ | _____ |
| b) Applying Legislation: legislation, regulations, statutes, policies, etc. | _____ | _____ | _____ |
| c) Applying Training/Development: applying new knowledge, skills, abilities, etc. | _____ | _____ | _____ |
| d) Decision Making: reaching sound and timely decisions. | _____ | _____ | _____ |
| e) Evaluating: weighing the significance of several inputs. | _____ | _____ | _____ |
| f) Interpreting: understanding the meaning of a situation, concept or problem. | _____ | _____ | _____ |
| g) Planning: participate in establishing the framework and processes for strategic planning. | _____ | _____ | _____ |
| h) Problem Solving: diagnosing situation, identify the cause and offer solutions. | _____ | _____ | _____ |
| i) Research: research written material, conduct interviews, etc. | _____ | _____ | _____ |

6) Leadership Skills

- | | | | |
|---|-------|-------|-------|
| a) Being a Team Player: working in a team environment. | _____ | _____ | _____ |
| b) Creating Vision: translating vision into measurable value added goals/objectives. | _____ | _____ | _____ |
| c) Displaying Initiative: demonstrating willingness to take on new challenges. | _____ | _____ | _____ |
| d) Encouraging Innovation: for self and others. | _____ | _____ | _____ |
| e) Ensuring Clear Values: ensures workplace values. | _____ | _____ | _____ |
| f) Leading by Example: setting examples for other to follow. | _____ | _____ | _____ |

	Not Important	Somewhat Important	Very Important
g) Motivating Others: increasing the productivity of others, creating positive attitude.	_____	_____	_____
h) Taking Calculated Risks: pursuing new opportunities.	_____	_____	_____
i) Understanding and Supporting Corporate Culture: understanding priorities, mission, etc.	_____	_____	_____
j) Valuing Diversity: respects workplace diversity.	_____	_____	_____
7) Self Management			
a) Demonstrating Coping Skills: developing/applying coping skills to stressful events.	_____	_____	_____
b) Demonstrating Flexibility: changing styles, adopt new approaches.	_____	_____	_____
c) Demonstrating Integrity: making actions match words.	_____	_____	_____
d) Demonstrating Motivation: personal motivation to do your best.	_____	_____	_____
e) Life Long Learning: using a variety of sources to obtain/maintain knowledge/skills.	_____	_____	_____

APPENDIX C

{date}

{name}

{title}

{address}

Winnipeg MB {pcode}

Dear {name},

My name is Robert (Bob) Rauscher, and I am currently a graduate student in the Faculty of Education, Department of Educational Administration, Foundations and Psychology at the University of Manitoba where I am completing a Master's degree in Adult Education. I am now in the process of conducting research for my thesis titled "The Changing Face of Manitoba Health: A Needs Assessment".

The purpose of the needs assessment study is to explore the skill sets that currently exists within Manitoba Health as it relates to the changing role(s) and function(s) of this organization. This study was presented and approved by the Executive Management team where it was identified that the data collected would be used to determine both the current and future organizational needs of Manitoba Health.

As you are a member of the Executive Management team, this letter is to request your participation in the needs assessment study. Specifically, it is hoped that you will allow approximately one hour of your time for an interview with myself which will be based on the enclosed interview guide. As a participant you are under no obligation to complete the study and you may withdraw at any time.

As part of the interview process, I plan to tape the entire interview. All tapes will be erased upon completion of the study. Each of the interviews will be identified by a code only. At no time will your name be used in association with the collected data, be found within the study, or in any other report coming out of the study. In addition, given the limited number of individuals being interviewed, I will only use direct quotes from the recorded interview with your permission. Upon completion, you will be provided with a complete summary of the research study including its findings and recommendations.

- 2 -

I will contact you in the near future to schedule an interview, should you be willing to participate in this study. I will also be requesting that you forward the completed consent form (attached) to me at that time. If you require further information regarding this study, I can be reached directly at 945-2749 during office hours. Additional information can also be acquired by contacting my thesis advisor, Dr. Deo Poonwassie, at the Department Educational Administration, Foundations and Psychology, Faculty of Education, University of Manitoba at 474-8244.

Thank you for your assistance.

Sincerely,

Robert Rauscher

APPENDIX D

Date

«FirstName» «LastName»
Manitoba Health
«Address1»

Dear «JobTitle» «LastName»,

My name is Robert Rauscher, and I am currently a graduate student in the Faculty of Education, Department of Educational Administration, Foundations and Psychology at the University of Manitoba where I am completing a Master's degree in Adult Education. I am now in the process of conducting research for my thesis titled "The Changing Face of Manitoba Health: A Needs Assessment".

The purpose of the needs assessment study is to explore the skill sets that currently exists within Manitoba Health as it relates to the changing role(s) and function(s) of this organization. Your name was among forty-two others randomly selected to participate in this study from Manitoba Health staff.

The needs assessment study will involve the completion of a computer-based survey and will require approximately 3 to 4 hours of your time. As Manitoba Health is in support of this study, the survey will be completed during regular business hours. A memo from Mr. Frank DeCock was sent giving permission for you to use work time for this purpose. To guarantee access to computer resources, the survey will be conducted at a downtown location with networked computer labs. Technical support will also be available.

All surveys will be coded to guarantee the confidentiality of all responses and only you will know what your code is. You may use your code identifier to retrieve an individualized printout of your survey results when the study is complete. All respondents will receive a summary report that will highlight the results of the entire study. The list of names of respondents will only be available to myself and will be destroyed upon completion of the study. Your name will not be used in any part of study or in any report subsequent to the study. Finally, your participation in this study is completely voluntary and you may withdraw at any time without penalty.

- 2 -

I will contact you in the near future to schedule you for the survey should you wish to participate. I will also be requesting that you forward the completed consent form (attached) to me at that time. If you require further information regarding this study, I can be reached directly at 945-2749 during office hours. Additional information can also be acquired by contacting my thesis advisor, Dr. Deo Poonwassie, at the Department Educational Administration, Foundations and Psychology, Faculty of Education, University of Manitoba at 474-8244.

Thank you for your assistance.

Sincerely,

Robert Rauscher

APPENDIX E

Participant Consent Form

I _____ freely consent to
(Print Name)
participate in the thesis study titled "*The Changing Face of
Manitoba Health: A Needs Assessment*" being conducted by
Robert Rauscher, a Graduate student of Educational
Administration, Foundations and Psychology, Faculty of
Education, University of Manitoba. The data collected as a
result of my involvement will be used towards the completion
of this thesis, as well as it may used in other reports
resulting from this study. I understand that my name will
not be used anywhere within this thesis study or any other
resulting reports.

I am aware that my participation is completely voluntary and
that I may withdraw from the study at any time without
penalty.

Signature

Date

APPENDIX F

Managerial: Financial

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Administering Estimates Process	planning/coordinating annual estimate process	2	19	7	3	5
B) Analyzing Corporate Finances	reviewing/analyzing financial structures	1	9	8	10	8
C) Analyzing Cost/Benefits	assess cost/benefits of programs	1	9	10	9	7
D) Analyzing Finances	using financial data to problem solve	2	4	10	14	7
E) Applying Accounting Principles	using appropriate accounting guidelines	1	3	10	11	11
F) Applying Financial Statement Concepts	understanding basic financial concepts	0	5	4	16	11
G) Auditing Costs	verifying costs	0	5	7	8	16
H) Auditing - External	verify external costs	0	1	4	14	17
I) Auditing - Internal	verify internal costs	0	6	5	11	14
J) Comptrollership	establish/maintain auditing structures	0	2	8	9	17
K) Cost Accounting	report on activity costs	1	6	8	10	11
L) Developing Business Cases	develop/submit financial business case	1	10	9	9	8
M) Developing Financial Systems	develop financial database systems	0	5	8	8	15
N) Developing Financial Policies	create and implement financial policies	0	1	8	10	17
O) Expenditure Plans	prepare fiscal plans	0	5	8	12	11
P) General Accounting	operate accounting systems	1	2	7	13	13
Q) Managing Finances	create value from financial activity	0	1	4	14	17
R) Preparing Financial Reports	prepare finance reports for internal use	1	6	10	8	14
S) Supporting Corporate Decisions	apply finance analysis to support decisions	0	3	12	8	13

Managerial: General Management

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Arbitrating	dispute resolution	1	9	8	10	8
B) Assessing & Implementing Ideas	assess value of new ideas to implementation	1	12	12	5	6
C) Assess Sensitivity of Information	recognize and determine sensitive information	4	19	6	5	2
D) Coaching/Advising	establish two-way communication	7	15	7	3	5
E) Conciliating	assists parties in dispute	1	14	7	6	8
F) Conducting Feasibility Studies	determines feasibility of new proposals	3	6	13	3	11
G) Developing Authority Seeking Documents	develops complex documents to submit for approvals	3	13	12	1	7
H) Executive Secretariat	coordinate secretariat activities	2	6	5	8	15
I) Impact Assessment	identify risks	3	16	3	7	7
J) Managing Change	Determine risks & benefits of change	3	11	10	5	7
K) Marketing	promoting goods/ideas	2	9	7	4	14
L) Mediating	act as impartial intermediary	2	9	4	6	15
M) Negotiating	work towards mutual agreement	1	15	9	6	6
N) Policies, Practices & Procedures	develop and implement	5	16	7	4	4
O) Providing Employee Development	links organization's and employees' needs	7	8	9	3	9
P) Providing Performance Appraisals	assess individuals' performance	4	17	2	2	11
Q) Conducting Investigations	coordinates external investigations	4	17	2	2	11

Managerial: Personnel & Industrial Relations

Core Sub-Skill	Description	Expert	In-depth	Operational	Emerging	No Skill
A) Administering Benefits	interprets & processes benefit entitlements	0	0	1	2	33
B) Administering Compensation Policies	developing/implementing compensation policies	0	0	2	1	33
C) Administering Human Resources	develop HR policies, procedure, programs	0	3	11	5	17
D) Administering Payroll	ensuring effective & efficient payroll	0	1	7	8	20
E) Auditing/Assessing	conducts audits	0	3	7	8	18
F) Classifying Jobs	analyses job standards	1	7	12	7	9
G) Collective Bargaining	negotiating collective agreements	0	2	4	11	19
H) Grievance & Arbitrating	investigate alleged violation of agreement	1	1	4	10	20
I) Human Resource Consulting	provide HR internal advice	1	5	11	4	15
J) Human Resource Planning	analyze current/future human resource needs	0	5	12	6	13
K) Labour Relations	Deal with employee - employer relations	0	3	6	11	16
L) Organizational Development	launching and managing change	2	7	10	4	13
M) Performance Measurement Systems	operate performance management systems	2	4	12	5	13
N) Staffing	Seek/hire appropriately skilled staff	4	9	10	1	12

APPENDIX G

Languages Spoken/Written - Staff

Language	Number Of Staff	Oral	Reading	Written
English	36	36	36	36
French	7	7	7	4
German	1	1	1	1
Spanish	1	1	1	0
Dutch	1	1	1	1
Ukrainian	2	2	0	0
Japanese	1	1	1	1
Gaelic	1	1	0	0

APPENDIX H

Training/Educational Levels by Category - Staff

Training/Education	Description
High School or Equivalent	Lowest level of training/education level noted was completed grade 10. All others possessed a complete grade 12 or equivalent.
Certificate or Diploma	<ul style="list-style-type: none"> ▪ Office Accounting & Bookkeeping ▪ Secretarial ▪ Library & Records ▪ Respiratory Technology ▪ Agricultural Technology ▪ Medical Terminology ▪ Occupational Health & Safety ▪ Criminology ▪ Emergency Medical Technology ▪ Critical Incident Stress ▪ Receptionist/Clerk Typist ▪ Microsoft Training ▪ Adult Education ▪ Registered Nurse
Undergraduate Degree	<ul style="list-style-type: none"> ▪ Physiotherapy ▪ Sociology ▪ Political Science ▪ Computer Science ▪ Psychology ▪ Pharmacy ▪ Public Health ▪ English Language ▪ Commerce ▪ Business Administration ▪ Nursing
Master	<ul style="list-style-type: none"> ▪ Health Specialization ▪ Public Administration ▪ Education - Counselling Services ▪ Nursing ▪ Industrial Management & Administration ▪ Health Policy & Administration ▪ Epidemiology