



**Interim Report on Health Reforms 2001
Research Project**

November 2003

Health Reforms 2001 Research Team

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Table of Contents

Letter from Minister of Health.....	vi
Executive Summary.....	vii
Acknowledgements.....	xix
Research Team.....	xx
Abbreviations.....	xxi
Glossary of Māori terms.....	xxiii
1 Introduction.....	1
2 Background: The Changing Health Structure.....	2
3 The 2001 Health Reforms: The NZPHDA Model.....	5
4 Research on the NZPHDA Model.....	7
4.1 Research Methodology.....	8
4.2 Key Themes of the Research.....	9
4.3 Research Streams and Methods.....	11
4.4 Ethics.....	14
4.5 Data Collection and Analysis.....	15
5 Overview of the Interim Findings Report.....	16
5.1 Introduction.....	16
5.2 Interpreting Findings.....	21
6 Interim Findings.....	24
6.1 Goals of the Reforms.....	24
6.2 The Rationale for the Structure Chosen.....	25
6.3 Public Perceptions of the Reforms.....	26
6.4 Governance.....	27
6.5 Strategic Decision-Making.....	47
6.6 Implementation of Key Strategies.....	53
6.7 Funding.....	62
6.8 Purchasing and Contracting.....	64
6.9 Treaty of Waitangi/ Māori Health.....	70
6.10 Pacific Peoples/Pacific Health.....	90
6.11 Devolution.....	95
6.12 Capacity/ Capability.....	99
6.13 Adaptation of the Ministry of Health to New Role.....	105
6.14 The NZPHDA Model.....	108
7 Summary and Issues for Follow-up.....	112

8	Summary of Discussions Following Feedback Sessions.....	120
	Appendix 1 Summary of New Zealanders' Views of the Health System 2001.....	133
	Appendix 2 Preliminary Analysis of Key Informant Interviews.....	136
	Appendix 3 Preliminary Analysis of Board Member Survey.....	172
	Appendix 4 Preliminary Analysis of CEO Interviews.....	190
	Appendix 5 Case Study Preliminary Analyses.....	198
	Appendix 6 Preliminary Analysis on Implementation of the Primary Health Care Strategy.....	223
	Appendix 7 Summary on Disability Support Services.....	228
	Appendix 8 Preliminary Analysis on Health Needs Assessment and Prioritisation.....	232
	Appendix 9 Summary on Shared Services Agencies.....	238
	Appendix 10 Summary on Regional Mental Health Networks.....	244
	References.....	250



Minister of Health
Minister for Food Safety
MP for Rongotai (incl Chatham Islands)

20 OCT 2003

Ms Jackie Cumming
Director
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Dear Ms Cumming

Interim Report of the Health Reforms 2001 Research Project

When Parliament passed the New Zealand Public Health and Disability Act 2000 I did not envisage that the perfect health and disability support sector would spring up overnight. It takes time, information, and willingness to continually improve.

For this reason I welcome this report. In taking the ground-breaking step of commissioning an independent evaluation I was seeking a dispassionate, rigorous, and impartial view of the health and disability sector, warts and all. Your report, and the numerous other presentations and feedback your team is providing, give us all in the sector the detailed information we need to improve its functioning.

I look forward to the second half of this project. The supporting information will help confirm aspects of the sector that are working well and not so well. It will allow us to assess the effectiveness of changes we make in response to issues you have highlighted and to identify further success factors to build on and traps to avoid.

Thank you, your team, District Health Boards, the Ministry of Health, their employees and other informants for your work so far and for your commitment to the ongoing improvement of the New Zealand health and disability sector.

Yours sincerely

Hon Annette King
MINISTER OF HEALTH

Executive Summary

The Health Reforms 2001 Research Project was undertaken to chart the progress of, and evaluate, as they were implemented, the health reforms enacted by the *New Zealand Public Health and Disability Act 2000*. This Interim Report is part of the first round of reporting the results of the research. As formative research, the results are being fed back into the sector as the information comes to hand. This report draws on analyses of data collected between January 2002 and May 2003, with the final reporting of the completed research process planned for mid-2005.

The health reforms implemented in 2001 have a number of features. First, central government developed a number of Strategies, in particular the New Zealand Health Strategy and the New Zealand Disability Strategy, to provide overall guidance to the health sector. Other Strategies have also been developed, including *He Korowai Oranga/The Māori Health Strategy; the Primary Health Care Strategy; and the Pacific Health and Disability Action Plan*. Second, the model establishes 21 district health boards (DHBs) as local agencies responsible for organising health care in their districts. DHB governing Boards have a majority of members who are elected; central government also appoints some members to Boards. DHBs undertake planning of services for their districts, they provide services through DHB ‘provider arms’ and they fund services delivered by non-DHB providers, with service agreements the mechanism for contracting for these services.

The three year research project involves a number of streams. Stream one collates the expectations and experiences of the model, using document analyses; key informant interviews with ministers, ministerial advisors, officials, national stakeholders and commentators; a postal survey of DHB Board members; interviews with DHB Chief Executive Officers (CEOs) and Chairs on a regular basis; and interviews with DHB Planning and Funding managers. The experiences and expectations of Māori and Pacific peoples are a particular focus of the research. Stream two examines five DHBs in greater depth. This involves more detailed document analysis; interviews with a range of DHB staff in both funding and provider arms of the DHBs; interviews with non-DHB providers and community stakeholders and commentators; and observational

studies of DHB Board meetings. The experiences and expectations of Māori and Pacific peoples are a particular focus of this stream of research also. Stream three documents the policy context in which the reforms are embedded, using primarily documentary sources. Stream four compares the model with previous models of organising health care, comparing the strengths and weaknesses of area health board (AHBs), regional health authority (RHA) and health funding authority (HFA) models.

The report begins by discussing the background to the 2001 health sector reforms, describing the changing nature of the health care sector in New Zealand over time, and describing the basic features of the model of health sector organisation established by the *New Zealand Public Health and Disability Act 2000* (hereafter referred to as ‘the model’). The report then sets out the background to this research, and describes the research methodology, themes and methods. The findings from the research are then presented, followed by an overall assessment of the implementation and performance of the model based on the research undertaken to date. There has also been a series of verbal feedback sessions to key sections of the health sector, which has given opportunity for discussion of these results. Summaries developed from notes taken at these meetings are included in this report.

The analysis of the data collected so far is still at an early stage; some of our findings are based on preliminary analyses only, and in some cases without triangulation of results across different sources of information. Such triangulation will occur as the analysis proceeds. The sources of the information reported here, and the limitations to their interpretation, are stated throughout this report.

Interim Findings

Overall, there is support for the new model. Results from the public survey show support for aspects of the model; CEOs see more strengths than weaknesses, and feel the weaknesses are manageable rather than seriously undermining the system; and data from the case studies show general support for the model because of the potential for, and initial experiences of, better local planning and relationships. National stakeholders interviewed gave mixed impressions, but two of the small number interviewed so far have observed that some DHBs, particularly the smaller ones, are becoming much more dynamic and innovative. There is a strong sense that the model is evolving over time, with those working in the sector learning and settling into new roles.

A number of issues relating to the model stand out, generally because of the consistency of message across data sources and districts, because of the strength of the comments made, or because key points have been raised about important parts of the model. These issues are set out below.

Governance

- There is concern at the low numbers of Māori elected to Boards, at no Pacific members being elected to Boards, and at a lack of transparency in the appointments process.
- There is support for having appointed members on Boards in order to add to the skill mix of Board members. There is a concern about the possible destabilizing impact that might occur following the next elections if there is a high turnover of elected members, given the effort put in to get relationships working and Boards up to speed. Conflicts of interest require careful management.
- Boards generally seem to be working well and Boards and managers also seem to be working well together. There are some tensions at times, particularly around perceived dual accountabilities to central government and local communities, and around clarity of the respective roles of the governing Boards and management.

- There is a concern that the governance structure, with three statutory Board committees, is excessive and costly to support. Disability Support Advisory Committee roles have been unclear.
- Although some CEOs had expected problems from opening meetings to the public, in practice there have been few problems with this. Few people attend the Board meetings although Community and Public Health Advisory Committee meetings in one case study DHB often attract more attendees. Open meetings are seen by some to constrain the debate necessary for good decision-making and Boards use workshops and closed sessions at times. Open board meetings are seen by some to be helpful in managing community expectations and allowing a more positive engagement with the media.
- Community involvement is seen as generating more responsive services. However, the election of members was not seen as contributing as much to community involvement as more structured processes.
- Performance monitoring by the Ministry of Health is seen as intrusive and demanding, and as consuming a significant amount of resource.

Strategic Decision-Making

- DHB Planning and Funding Managers were positive about the benefits of the health needs assessments for planning. However, there was not always a good connection between prioritisation, district strategic plans, district annual plans and budgeting. Where there were strong connections it was because time frames and planning processes were synchronized, there was stakeholder involvement and planning team expertise. Engagement with Māori was not always done well.
- Government strategies do appear to be of importance to Board planning, but it is too early to say if budgeting, service mix and volume changes reflect the strategies. Information on this will be sought as the research continues.

- There is a perceived lack of clarity about the locus of decision-making. The DHBs are charged with needs assessments and prioritisation, yet the Ministry is seen to have the discretionary spending power, to place constraints on local decisions through national frameworks, and is sometimes seen as interfering with local preferences.
- Board meetings are open to the public, but generally public attendance is low. Some CEOs regard the more structured processes used as part of strategic planning as a more effective way of involving the community in the work of the Board

Implementation of Key Strategies

- Those responding to the DHB Board Member survey did seem to reflect the broad objectives of DHBs set out in legislation and the priorities set out in the *NZ Health Strategy*, *NZ Disability Strategy*, *the Primary Health Care Strategy* and *He Korowai Oranga/The Māori Health Strategy*. The seven DHBs with significant Pacific populations did not score Pacific health more highly than other DHBs.
- Some parts of the health sector appear to be confused in their understanding of the *NZ Disability Strategy* and some DHBs appear to have been slower in recognising the sector's responsibilities in implementing the Strategy.
- Although there is general agreement with the principles and aims of *The Primary Health Care Strategy*, informants in the sector have expressed concerns about consultation and implementation processes.

Funding

- All CEOs acknowledged the expectation was that they live within budget, and that they reduce their deficits within three years. The three year funding pathway was seen as helpful, but cost drivers beyond the control of DHBs were seen as needing attention nationally.

- Some concerns were raised about the ability of DHBs to achieve all that is desired of them. Population-based funding formula also raised concerns due to the use of out-of-date data¹, potential lack of recognition of DHB-specific features and the potential impact on patient choice where funding no longer automatically follows the patient.

Purchasing and Contracting

- The initial round of devolution of contracts was problematic because the DHBs were not provided with adequate and timely information to undertake due diligence.
- Non-DHB providers raise concerns over accountability requirements; a lack of focus on outcomes in contracts; the potential impact from DHBs being both funders and providers of health care services; and the potential impact of having to work with more than one DHB or with DHBs and the Ministry of Health.
- The national stakeholders interviewed so far (mostly national non-government organisations) reported mixed impressions with some DHBs being seen as still locked into the “old ways of contracting” whereas other DHBs, particularly the smaller ones, are seen as becoming much more dynamic and innovative, despite their lack of capacity.

Treaty of Waitangi and Māori Health

- Several of the key informants felt the inclusion of the Treaty of Waitangi in the *New Zealand Public Health and Disability Act 2000* was significant and see it as a platform DHBs that Māori can use to build relationships with DHBs and to improve Māori health outcomes.

¹ Projections based on 1996 census data will be used for 2003/04 population-based funding formula; projections based on 2001 census data will be used for 2004/05 funding (personal communication, Ministry of Health).

- The Act has also enabled the appointment of two Māori Board members on each DHB, ensuring representation regardless of the outcome of the election process. This participation by Māori at a governance level is seen as a welcome step forward.
- Also positively received are the explicit goals for Māori, a more holistic approach to health and an increasing focus on primary health care.
- However the new local Treaty relationship raises concerns for Māori, as Māori have a long history and confidence in dealing with Central government. Māori feel they have not always fared well as the hands of local bodies. To date, a variety of arrangements have been put in place, but there are still some on DHB Boards who do not support the Treaty and this is uncomfortable for Māori.
- Concerns were also expressed that change requires political commitment to Māori health, sufficient funding and there was some cynicism over the capability of the system to deliver gains for Māori given a long history of inadequate care by mainstream providers and the level of inequalities experienced by Māori. The expectations of the Treaty relationship as expressed by case study informants are that Māori and non-Māori health status should be brought up to the same level, that resource allocation is fair and Māori have the right to determine their own system of health care delivery.
- Although there was disappointment that the *manawhenua* clause was not enacted, at the DHB level the relationship is often with *manawhenua* anyway. The *manawhenua* in four of the case study sites have included *taurahere* or *mātāwaka* in the governance level arrangements. Some DHBs have also established links with local *iwi* and Māori communities.

- *He Korowai Oranga/The Māori Health Strategy and Whakatātaka/The Māori Health Action Plan* were launched in November 2002. Some concerns were expressed about the process of developing the Strategy, but it is thought that the Strategy builds on past gains and is designed to move forward. It is also expected to be a useful tool for DHBs to reach communities with poor access to health care resources.
- The definition of whānau ora is one where there are diverse views, with a need for further education on what whānau is. While seen as a strengths-based approach, it requires DHBs and mainstream providers to revisit and rethink the way in which services are delivered to Māori. At the moment services are delivered on an individualistic pakeha model of healthcare. It is thought whānau, hapu and iwi should all have direct input into service planning and delivery.
- While the development of Primary Health Organisations was seen as positive because of likely increased access to primary care, it was noted that there are risks for Māori health providers. Informants argue that the unique services they provide must be protected.

Pacific Peoples and Pacific Health

- The recent health reforms are seen in a positive light by the Pacific community and providers. Although it is seen as an evolution of previous models, it is positive in terms of the non-competitive model for the providers, development of *The Pacific Health and Disability Action Plan*, selecting specific DHBs with high Pacific populations to become priority DHBs and in some DHBs, encouraging Pacific issues to the forefront.
- There are issues that need further research and analysis based on the interim findings. They include DHB consultation with community/providers and the processes involved with this; workforce development, career pathways and employment issues for Pacific people; Primary Health Organisations and what they mean for Pacific communities, and DHB monitoring of contracts. There is a need to examine in detail across the DHBs that are priority DHBs.

- The research that is being presently undertaken has provided the Pacific peoples with a rare opportunity to voice their opinions about the changing reforms.

Devolution

- Informants indicate strong perceptions of reluctance to devolve funding and decision-making on the part of the Ministry of Health. DHBs are also concerned about the degree of autonomy they have in decision-making.

Capacity and Capability

- The current model is seen by some to have fragmented the critical mass of expertise that had been formed under the HFA, leaving DHBs with a lack of capacity for many of their assumed or prospective roles.
- DHBs are developing working relationships with each other, including at a service level, and the Shared Services Agencies seem to be working well. There is less clarity over the role of the Regional Mental Health Networks and some concerns that new funding for mental health was allocated regionally rather than to individual DHBs.
- The DHBNZ organization arose initially to assist with the transition to DHBs but has evolved to have a strategic role in communications with the Ministry of Health, and as a discussion and information-sharing forum for DHBs.

Adaptation of the Ministry of Health to New Role

- CEOs reported their relationship with the Ministry of Health was either good or improving; they acknowledged the difficulties faced by the Ministry in implementing the reforms in a relatively short time period, and there was high regard for senior Ministry officials.

- CEOs call for better co-ordination within the Ministry of Health; and note a number of performance issues. DHBs look to the Ministry for strong leadership, a co-ordinated approach and strong policy development.
- There is a degree of concern about a lack of autonomy for DHBs and a sense of the Ministry of Health being too involved in DHB matters.
- Some expressed the view that the Ministry of Health should downsize and concentrate on national strategy.
- Although relationships can be strained at times, they are seen to be good at an individual level, particularly with the account managers. CEOs expect more appropriate relationships over time.

NZPHDA Model

- There appears to be support for the model, with reports of a number of strengths from the model, including:
 - the ability to look regionally at the needs of the population
 - the ability to involve community in decision-making
 - the opportunity to be more locally responsive, in particular the opportunity for better local planning and better local relationships
 - enhanced engagement with providers at the local level
 - a focus on inequalities
 - the increased focus on primary health care, and
 - increased transparency (eg clinical priorities with national waiting list model and finances) promoting more honest public expectations.
- CEOs see more strengths with the model than weaknesses, and they suggest that most weaknesses are manageable, do not seriously undermine the system and believe that many difficulties will be overcome over time. There are already reports of improvements in relationships and processes over the period of time that the research data has been collected. A number of people we have spoken to

have expectations of further improvements. Moreover, major change does not appear to be recommended at this stage. This may be in part related to ‘change fatigue’ and a desire to let a new structure settle in and evolve gradually rather than be subjected to further disruption, but it also seems to be a reflection of overall support for the model.

- Many believe there are too many DHBs, leading to high transaction costs and too much duplication of effort. Some expect amalgamations, although no DHBs are yet ‘putting their hands up’ to amalgamate.
- Some in the sector are also worried that Primary Health Organisations, set up under the *Primary Health Care Strategy*, also add an extra layer of bureaucracy, further increasing ‘management’ costs in the sector. Smaller non-government providers are also concerned that PHOs will ‘take over’ their organisations or roles, in order to reduce transaction costs or expand their own roles, resulting in a potential loss of flexibility and innovation that smaller providers are seen to bring to the sector.

Implications Arising from the Research

As formative research the major purpose of this project at this stage is to inform those policy advisers, policy makers, DHBs, providers and the community about the recent experience of this model of health service organisation. Even at this early stage of the research there are some issues which are identifiable as aspects worthy of attention in the ongoing efforts to improve the implementation and performance of the reformed model. These are listed below to stimulate thought and application and will also be the focus of ongoing research efforts.

1. What strategies can be developed to ensure adequate, appropriate and effective Māori representation on Boards? How can this representation be supported to allow this input into governance to make a real difference to strategic planning?

2. Is there the right balance between national priorities, set by central government, and the freedom to choose at the local level? Do DHBs have sufficient scope and flexibility to effectively use the health needs assessments and priority setting processes to draw up strategic and annual plans, and then to implement the changes indicated?
3. How can local provider monopolies be avoided, and innovation and contestability be safeguarded? There is anxiety that the costs of contracting with a number of providers, and having a provider arm in DHBs, will work against smaller organisations, but should this be proven true before safeguards are put in place? Are smaller organisations more dynamic and innovative, and what guides can be used to promote the optimal balance of provision matched with need?
4. What is the most appropriate relationship between the DHBs and the Ministry of Health? Possibly the logical future model of relationship is one of partnership, with equal partners carrying out different roles. If that is the case, what does that mean in practice? What changes need to be made to obtain such partnership?
5. Is the reporting model the most appropriate model by which the Ministry monitors DHBs? Could some of the reporting requirements be streamlined or an alternative system instituted?
6. How can Pacific Health be kept visible and to the forefront in the priority DHBs?
7. How can further cooperation between DHBs enhance the NZPHDA model? Are there ways of encouraging cooperation, e.g. by structuring incentives, or should it be allowed to evolve naturally from the “grassroots”?
8. Will the split of funding in disability services promote the optimal coordination of services and planning and keep transaction costs to a minimum?
9. How can the DHBs and Primary Health Organisations work together to reduce transaction and bureaucratic costs, and to optimally promote the health and independence of the local population?

Acknowledgements

This research would not have been possible without the generous financial support of the Health Research Council of New Zealand, and the Ministry of Health, Treasury and State Services Commission, who have co-funded the research through the Ministry of Research, Science and Technology Departmental Contestable Research Pool. The Research Advisory Support Group, which includes representatives from these funding organisations, oversees this project, to ensure the research is timely, of a high quality and will meet its aims. The support of the members of this group is gratefully acknowledged. Thanks are also due to all the many people who have so willingly given their time to participate in the research, whether through interviews, surveys, answering telephone queries or otherwise supporting our research efforts. The contributions of all who have been involved are much appreciated. It has allowed this research to proceed with the independence that it requires, in the spirit of constructive evaluation.

Mihi

Ē ngā mana

Ē ngā reo

Rau rangatira mā

Tēna koutou, tēna koutou

Ngā mate, ngā aitūa,

Ō koutou, ō mātou,

Ka tangihia e tātou i tēnei wā,

Haere, haere, haere.

Te hunga ora

Tēna koutou katoa.

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Abbreviations

ACC	Accident Compensation Corporation
AHB	Area Health Board
Board	District Health Board Governing Board
CHE	Crown Health Enterprise
CEO	DHB Chief Executive Officer
CPHAC	Community and Public Health Advisory Committee
DHB	District Health Board (The Organisation)
DHBNZ	District Health Boards New Zealand
DSAC	Disability Support Advisory Committee
DAP	District Annual Plan
DSP	District Strategic Plan
F&P	Funding and Planning
HAC	Hospital Advisory Committee
HFA	Health Funding Authority
HHS	Hospital and Health Service
HNA	Health Needs Assessment
MHC	Mental Health Commission
Ministry	Ministry of Health
NGO	Non-Government Organisation
NDSA	Northern District Health Board Support Agency
NZDS	<i>NZ Disability Strategy</i>
NZHS	<i>NZ Health Strategy</i>
NZPHDA	<i>NZ Public Health and Disability Act</i>
ODI	Office of Disability Issues

PBFF	Population based funding formula
PHCS	<i>Primary Health Care Strategy</i>
PHO	Primary Health Organisation
RHA	Regional Health Authority
RMHN	Regional Mental Health Network
SISSAL	South Island Shared Service Agency
SSA	Shared Services Agency
TAS	Central Region Technical Advisory Agency

Glossary of Māori Terms

Awa	River
Awhi	Embrace
Hapu	Sub-tribe
Iwi	Tribe
Kaumaatua	Elders
Kawanatanga	Government
Mana motuhake	Autonomy
Manaaki	Show respect or kindness
Manawhenua	Authority of the land, referring to where a group of people come from
Marae	Meeting place
Mātāwaka	Multiple canoes. Used in the same way as taurahere
Maunga	Mountain
Mauri ora	To be
Mauri	Life principle
Tangata whenua	People of the land
Taurahere	The rope that binds us. Used metaphorically to describe Māori groups living in another tribal area
Tautoko	Support
Tiaki	Guard, care for
Whānau	Family
Whakapapa	Genealogy
Whenua	Land

1 Introduction

The Health Reforms 2001 Research Project was undertaken to chart the progress of, and evaluate, as they were implemented, the health reforms enacted by the *New Zealand Public Health and Disability Act 2000*. This research is ground-breaking, as it is the first time in New Zealand that a nation-wide reform process has been charted as it occurs. The current research is funded for three years. Timely feedback to the sector, including policy makers and District Health Boards (DHBs), is an essential part of the research process. This Interim Report is part of the first round of reporting the results of the research.

The report begins by discussing the background to the 2001 health sector reforms, describing the changing nature of the health care sector in New Zealand over time, and describing the basic features of the 2001 reforms. The report then sets out the background to this research, and describes the research methodology, themes and methods. This is followed by an overview of the research undertaken to date and the data sources used in this report. The findings from the research are then presented, followed by an overall assessment of the implementation and performance of the model based on the research undertaken so far. A number of Appendices are attached to the Report. These summarise results from parts of the research undertaken to date. They include: Summary of New Zealanders' Views on the Health System 2001; Preliminary Analysis of Key Informant Interviews; Preliminary Analysis of Board Member Survey; Preliminary Analysis of CEO Interviews; Case Study Preliminary Analyses; Preliminary Analysis on Implementation of *The Primary Health Care Strategy*; Summary on Disability Support Services; Preliminary Analysis on Health Needs Assessments and Prioritisation; and summary reports on Shared Services Agencies and Regional Mental Health Networks.

2 Background: The Changing Health Care Structure

The NZ health care system became predominantly publicly-funded in the late 1930s. At first, funding was through a mix of central and local government taxes but central government became the predominant funder of health care in the late 1950s. Since that time, the organisation of funding for the health care system has remained more or less unchanged. That is, hospital care and public health services are provided free of charge. Primary care is subsidised by government, particularly for those on lower incomes. All users pay some charges for primary care, but those on higher incomes pay the full cost of much primary health care. Disability support services (DSS) were brought into the health sector funding in the early 1990s. Here, needs are assessed at an individual level and there is income and asset testing to determine eligibility for publicly-funded care. A parallel private health insurance system offers those who can afford it faster access to, and private facilities for, elective care, as well as insurance coverage for user charges². There is separate social insurance funding for accident-related prevention, care and rehabilitation through ACC.

Although funding arrangements have remained largely the same for many years, the structure of the New Zealand health system of purchasing and delivery has undergone a number of reforms. Prior to the 1970s, the main changes to occur were the amalgamations of small hospital boards into larger units. In the late 1970s, the National government developed proposals for the amalgamation of 27 publicly-owned hospital boards with 18 public health units (regional offices of the Department of Health) to form 14 publicly-owned area health boards (AHBs). Wellington and Northland pilots were established first, followed by the establishment of AHBs throughout the country in the 1980s (Gauld, 2001). AHBs originally were eventually governed by a mix of elected and central government-appointed Board members (Gauld, 2001). AHBs became responsible for taking a 'population' approach, focusing on the health of their populations, and the planning and meeting of health and health care needs for those populations.

² The amount of funding and the proportions paid from public and private sources have changed over time. See Ministry of Health 2002.

AHBs were funded using a weighted population-based funding formula, although funding for primary care remained separately distributed by the Department of Health³. Central government implemented stronger accountability requirements for AHBs, focusing on Health Goals and Targets and setting in place a basic system of contracting with each AHB (Clark, 1989), as well as making the AHB Board Chair clearly accountable to the Minister of Health (Gauld, 2001).

AHBs were only just in place across the whole country when a change of central government in 1990 saw a major review of the organisation of the health system, and a new approach to purchasing and delivery was implemented in 1993. The then National government explicitly separated purchasing and provision functions of AHBs. Four regionally-based purchasers (regional health authorities or RHAs) were established to plan and purchase a wide range of services – public health, personal health and disability support services – and the government turned the provider-arms of the 14 AHBs into 23 Crown health enterprises (CHEs). CHEs were established under a business model, required to make a profit, and to compete with a wide range of other service providers for contracts with the four purchasers. Purchasers could contract with CHEs, privately-owned medical and surgical and residential hospitals, and privately-owned for-profit and not-for-profit primary and community care providers. Both RHA and CHE board members were appointed by central government, such that decisions about health services were being made by boards that no longer included elected members. User charges were introduced by government for hospital services, although these were scrapped a year after their introduction (Gauld, 2001).

³ It had always been the intention to integrate primary care funding with secondary care funding through AHBs; however, this never occurred, partly for fear of creating 14 different primary health care systems (McKinlay 1990).

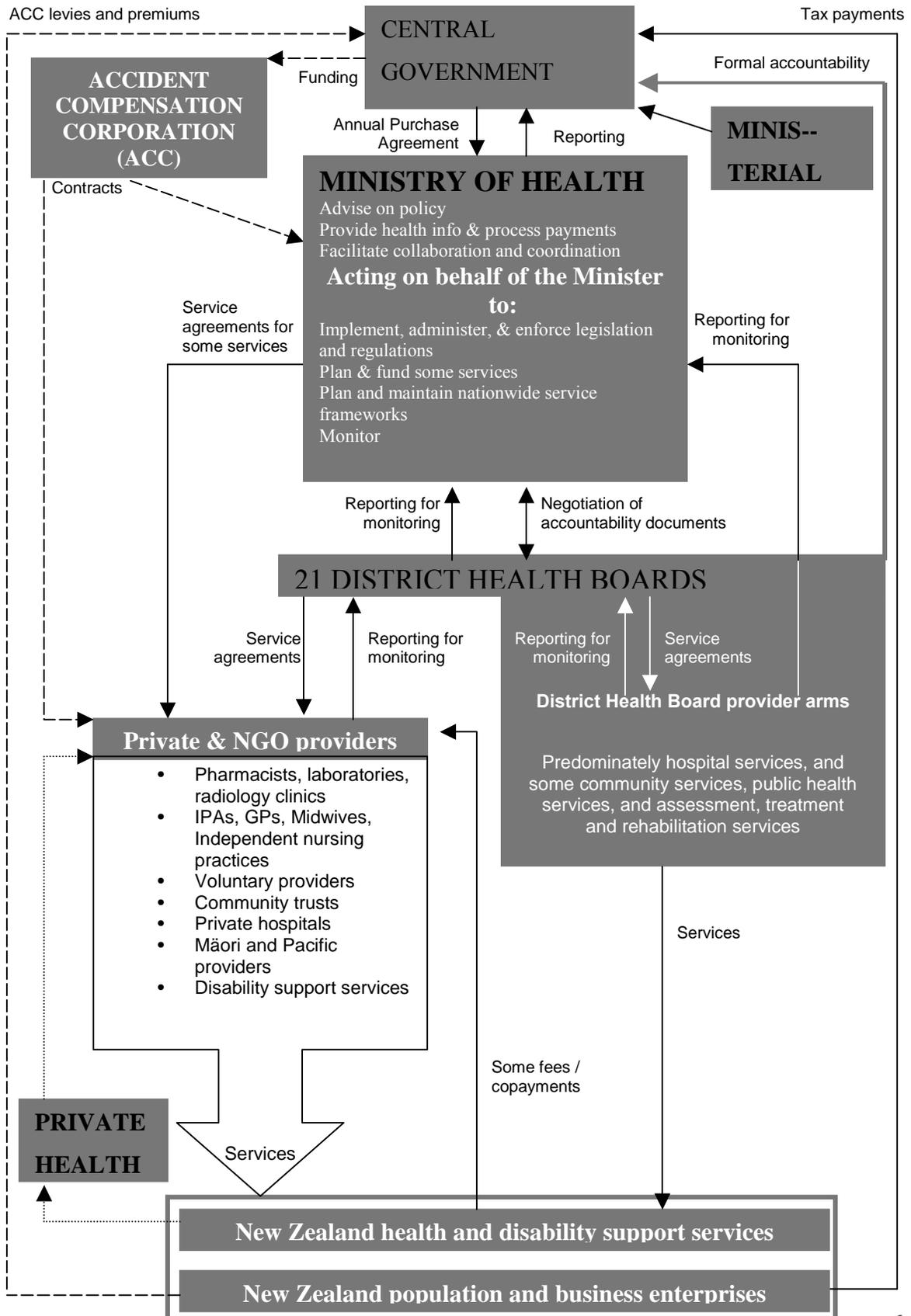
This 'purchaser-provider' or 'quasi'-market model, was extremely controversial – it was the focus of much negative media attention and was constantly criticised by groups of health professionals. The 'quasi-market' model itself underwent a number of changes. There was an amalgamation of the RHAs into a single, national purchaser (the Health Funding Authority or HFA) in 1997 and the gradual move away from a competitive model towards a more co-operative model. CHEs became Hospital and Health Services (HHSs) in the same year, and were no longer required to earn a profit but expected to remain within budget. Contracting between purchasing and providing agencies remained throughout the period.

3 The 2001 Health Reforms: The NZPHDA Model

A newly-elected Labour government came to power in late 1999, promising significant change to the organisation of health care purchasing and provision. The resulting New Zealand Public Health and Disability model (hereafter referred to as the model), named after its governing *New Zealand Public Health and Disability Act 2000* (hereafter referred to as the Act) was implemented from January 2001. The model includes the development of over-arching health strategies to set national priorities and the establishment of 21 District Health Boards (DHBs) to purchase and provide or arrange for the provision of services for geographically defined populations. DHBs are governed by Boards of up to 11 members, the majority elected. Central government appoints up to four members. Funding for health services is devolved to these Boards, which are responsible for purchasing and provision of hospital care and for funding/contracting with community and primary care providers. There is upwards accountability directly to the Minister of Health, with the Ministry of Health acting as the Minister's agent, (hereafter referred to respectively as the Minister and the Ministry). Emphasis is placed on local, cooperative, collaborative arrangements. The structure of the sector is set out in Figure 1. See also Section 6.4 for the other changes introduced as part of the reforms.

THE NEW ZEALAND HEALTH AND DISABILITY SUPPORT SECTOR

Source: Ministry of Health



4 Research on the NZPHDA Model

As the Act and the detail associated with the model were being finalised, a team of independent academic researchers submitted a grant application to the Health Research Council of New Zealand to research aspects of the model. The focus of the research was to be on governance, strategic decision-making, purchasing and accountability. The implementation of the model was to be documented, commented on and the potential to meet government health goals assessed. The research was also to document and analyse strengths and weaknesses of alternative ways of organising strategic decision-making, governance, purchasing and accountability which develop under the Act. The strengths and weaknesses of this model were to be compared to the quasi-market model represented by the RHA/HFA models of health service organisation. An important component of the research was to evaluate the nature and impact of the reforms on the partnership, protection and participation of Māori. This research application was successful and funding was granted for a three-year project to research these reforms.

At the same time, key government Ministries – the Ministry of Health, the Treasury and the State Services Commission – obtained funding from a Ministry of Research, Science and Technology Departmental Contestable Research Pool for research into the reforms. The government Ministries sought a more formative evaluation and inclusion of additional themes, such as evaluating the implementation of key Strategies, looking at the role of Pacific peoples in the new model and the impact of the model on health services for Pacific peoples, evaluating how the Ministry of Health adapts to a new role, looking at issues of capability and capacity in the sector, considering how relationships between DHBs and health professionals develop, assessing the extent to which the reforms have re-established public faith in the role of government, and considering the wider lessons for public management arising from the reforms. The two funding sources were pooled to enable a single team of researchers to manage the research.

4.1 Research Methodology

The overarching approach is an evaluation framework, in particular a mix of goal-attainment, side-effects, comprehensive and stakeholder evaluation models (Vedung 1997). The evaluation has a significant formative component, focusing on identifying and commenting on progress in implementing the new health system and the Government's goals for the sector. It also includes a comparative evaluation, by comparing this model with previous models. Theoretical frameworks and predictions, arising from a number of public policy, economic and health policy literatures, have been used to frame the research and to identify the key issues on which the research is to focus.

The research is a three year evaluation study, running in parallel as the reforms are implemented from 2001 to 2004. Key objectives are to:

- Identify features of the model and government goals for the sector.
- Identify stakeholder goals, concerns and issues with the model and other key components of government health policy.
- Document the activities and actions that the Ministry of Health and DHBs undertake to implement the model and the structures that develop to support the model.
- Assess the implications of these activities and actions for the implementation of the model, in terms of:
 - government policies – are government policies being implemented as signalled; will these policies help in achieving government goals
 - DHB policies – are DHB policies being implemented as signalled; will these policies help in achieving DHB goals
 - other stakeholder policies – are other stakeholders' interests being addressed as signalled; will these policies help in achieving stakeholder goals.

- Identify where key activities and actions are being performed well or in innovative ways as well as where activities might be done better, compared to:
 - stakeholder-defined standards (Ministry of Health, DHB, other stakeholders)
 - how activities and actions were undertaken in the past.
 - standards drawn from the literature/research team knowledge
- Draw conclusions about the strengths and weaknesses of the model as originally planned and as implemented, based on findings above, by:
 - identifying key indicators of performance and assessing Ministry of Health and DHB performance against each indicator and against the HFA model
 - determining which characteristics of the Ministry of Health/DHBs, approaches used by the Ministry of Health/DHBs and the contexts in which the Ministry of Health/DHBs operate are related to good performance against key indicators.

4.2 Key Themes of the Research

The project focuses investigation on key themes which have been identified as central to the Health Reforms 2001:

- Governance
- Strategic decision-making
- Implementation of key strategies
- Funding
- Purchasing and contracting
- Treaty of Waitangi and Māori health
- Pacific peoples and Pacific health
- Devolution
- Capacity and capability
- Adaptation of the Ministry of Health to new role
- NZPHDA model.

The research is focused particularly on processes, i.e., on how the model is being implemented and how it is operating. This is for three major reasons: i) because the government's objectives appear to be largely process-related; ii) because much of the performance management framework for DHBs is process or service-oriented and the research team is drawing on this material for some of its analyses; and iii) because it is not possible to assess the health and economic outcomes associated with reforms such as these, as this is only a three year project and as many other factors play a role in determining health outcomes.

However, attention is also paid to the perceived impact of the reforms on health and economic outcomes, i.e. on how health status or efficiency changes. In addition, a framework for interpreting available data on health and economic outcomes will be developed. We will collate and analyse routinely collected quantitative data, such as data on health service use and health status, and on health expenditure trends, DHB budgets and deficits and DHB financial allocations (purchaser/provider arm, key service categories, Māori and Pacific providers). Comparisons between HFA/Ministry and Ministry/DHB full-time equivalents and expenditure will be made where comparable data are available. Where possible, we will analyse some proxy measures of health status already collected as part of the performance management system, hospital length of stay and percentage day surgery and hospital staff turnover. The quality of the data and the number of potentially confounding factors will, however, will make it difficult to use such data to definitively comment on health and economic outcomes associated with the model.

4.3 Research Streams and Methods

The research is being conducted in four concurrent streams. Stream one collates the expectations and experiences of the model with regard to the themes identified as of interest in the research. Data sources include document analysis; key informant interviews with ministers, officials and others; a postal survey of all Board members; and interviews with all DHB Chief Executive Officers (CEOs) and Chairs on a regular basis, and Planning and Funding Managers once (from 20 participating DHBs⁴). Stream two examines five DHBs in greater depth. This involves more detailed document analysis, interviews with a range of DHB employees and with key stakeholders in the community, including providers, and observational studies of Board meetings. Stream three documents the policy context in which the reforms are embedded. This is necessary for the interpretation of results. Stream four compares this model with the previous AHB, RHA and HFA models. Document analysis, literature reviews and some interview material from informants with long experience in the health sector and stakeholders is used to describe, analyse, and contrast approaches to key tasks.

The research utilises both qualitative and quantitative methods. The following methods are being used, with the timing of the research in brackets:

- Public telephone survey (Mid-2001)
 - A telephone survey was carried out by BRC Marketing & Social Research. A random sample was taken of New Zealanders listed on the General Electoral Roll, and Māori were selected in a booster sample using the Māori Electoral Roll. The response rate was 40% (39% for non-Māori, 44% for Māori). The fifteen minute telephone survey of 504 New Zealand citizens, including 95 Māori, was conducted in June-July 2001, at the beginning of the reform process.

- Document analysis (On-going)

⁴ One DHB has so far chosen not to participate in the research.

- Documents from 20 participating DHBs being analysed include: health needs assessments, district strategic plans, district annual plans, statements of intent, annual reports, financial reports and other material as relevant.
- In addition relevant Ministry documents and cabinet papers are being analysed.
- Key informant interviews (2002, 2004)
 - Nineteen interviews were conducted with seventeen key informants, including ministers, officials, coalition government spokespeople on health, opposition spokespeople on health. Separate key informant interviews were held with Māori and Pacific ministers, officials, and national commentators on health. The aim of the interviews was to identify the goals and expectations of the reformed model, to identify key issues expected to arise from the model and to discuss early experiences with the model.
- Postal questionnaires to DHB Board members (2002, 2004)
 - Postal questionnaires were sent out to all Board members in 20 participating DHBs. Two approaches were used. First, Likert scales were used, where respondents noted if they strongly disagreed, disagreed, neither disagreed nor agreed, agreed or strongly agreed with statements relating to key topics of the research. Second, questions allowing 'free text' responses were used. The questionnaire had a response rate of 66%; varying from 45% to 82% across DHBs.
- Interviews with DHB Chairs and CEOs (1 per year, 2002-2004)
- Interviews with Planning and Funding Managers (2002)
 - These focused on experiences of the needs assessment and prioritisation processes used by DHBs in 2001/2002.

As part of our research method, five districts have been selected as case study sites. Research in these case study sites is designed to allow closer examination of DHB decision-making, governance and accountability. These five DHBs were chosen to be representative of DHBs with different characteristics. They serve small, medium and large populations, communities with different age and ethnic mixes and cover urban, rural and provincial communities. The financial situation of these case study DHBs also differs.

The case studies involve (2002, 2004):

- Document analysis.
- Key informant interviews - DHB Chairs, DHB Statutory Committee Chairs, CEOs, DHB senior managers in both the funding and provider arms, non-DHB providers of services, local stakeholders and community commentators; also Māori and Pacific Board members and Managers, and Māori and Pacific providers.
- Observation studies of Board meetings - Board meeting observations are being carried out at each of the five case study DHBs over three consecutive meetings from April to July 2003. Using templates designed for the project, based on the literature and on informal observations, each Board observation is carried out by two researchers. A narrative report and a matrix are used to track the flow and content of the meetings, and the interaction and participation of the Board members and other participants. These data will then be triangulated with Board minutes and interview data, to establish the activities and culture of Boards.

Additional interviews and document analyses are also being undertaken on particular topics, including in relation to the implementation of *The Primary Health Care Strategy* (PHCS), the New Zealand Disability Strategy (NZDS) and issues relating to disability support services (DSS), and in relation to the development of Shared Services Agencies (SSAs) and the Regional Mental Health Networks (RMHNS).

In addition, we will undertake a quantitative analysis of administrative data on expenditure levels and allocations, financial performance, outputs, and intermediate health outcomes, to place the reforms into context and to explore the performance of the model using performance data.

The research process is an important feature of this project. The approach taken recognises the importance of good relationships between the research team members and participants in the research. The case study methodology, in particular, uses local knowledge and relationships to understand the context in which the DHB model is being implemented, including recognition of local issues.

The feedback of findings to the sector is an important aspect of the research plan. This interim report is an early step in this feedback process. Discussion arising from feedback will be taken into account in fine-tuning the process of data collection in the following phases of the research, to deepen understanding of the main issues of interest and debate.

4.4 Ethics

The research plans were submitted for ethical consideration to the Wellington Ethics Committee. The committee decided that this project did not require formal ethical approval. However, the Research Team agreed with the Committee on stringent adherence to sound ethical research practice. Therefore the following steps were incorporated:

- Potential participants were given the right to decline to take part.
- The consent form committed the researcher to send a transcript of the interview for perusal and possible amendment, unless the interview subject waived this step.
- Participants were given the option of withdrawing their involvement and statements at any time.
- Data is to be stored for 10 years.
- Analysis and reporting protects the identification of individual informants and DHBs.

- Māori and Pacific researchers are used to maintain cultural consistency with culturally sensitive aspects of the research.

4.5 Data Collection and Analysis

In selecting people for interview, we are focusing on people who have been instrumental in developing and implementing the reforms. Where possible, interviews are face-to-face, but if this is not possible, interviews are conducted by telephone. Semi-structured interview schedules are developed with the same schedule being used for people in the same, or similar, roles across the Boards. Interviews are taped with the interviewee's permission, and tapes transcribed, checked and, unless otherwise requested, returned to interviewees to make any desired changes. Where interviews are not taped, notes are taken, written up and returned to interviewees for checking.

Interviews and documents are being analysed by a process of thematic analysis. All transcripts are entered into an NVivo database. Themes are agreed by the research team. Transcripts are coded by theme, with the data being separated out into themes and sub-coded. Themes are then compared across interviews by one member of the research team and written up. Documents are also being analysed using similar thematic analysis techniques.

The Board member survey consisted of statements with which respondents were invited to strongly agree, agree, neither agree nor disagree, disagree or strongly disagree (using Likert scales). The survey was then analysed using descriptive statistical analysis (using SAS and SPSS), which converted the data into summary statistics.

Document analysis and observational techniques are used in triangulation with information from interviews and from the Board member survey, i.e. to identify if key activities and actions discussed in interviews are supported by documentation. Similarly, performance data will be triangulated with other data sources.

5 Overview of the Interim Findings Report

5.1 Introduction

This report presents the findings at this interim stage of the research process, from the first eighteen months of data collection. The analysis of the data collected so far is still at an early stage; some of our findings are based on preliminary analyses only, and in some cases without triangulation of results across different sources of information. Such triangulation will occur as the research proceeds:

- Data collection began mid-2001, with a survey gauging public opinion on aspects of the reforms. A full analysis of these data has been completed, and a summary of the results from this survey is included in this report.
- Key informants, including a range of ministers, officials, coalition government spokespeople on health, and opposition spokespeople on health, were interviewed in early 2002, to gather information on expectations and early experiences of the reforms. Analysis of data from these interviews is almost fully completed and a preliminary analysis of data from these interviews is also included here.
- DHB Board members were surveyed using a postal questionnaire in April 2002, and preliminary results from this are covered in this report.
- CEOs in DHBs have also been interviewed (late 2002 to early 2003) and a preliminary analysis of these interviews is reported here. Some Chairs have also been interviewed and some data from these interviews are reported here; data from further interviews will be included in later reports.
- This report provides a preliminary analysis of documentation, data from the first round of interviews and Board observations in the five case study districts, with the full analysis due at the end of 2003.

- The report provides a summary of the interim analysis of data from key informant interviews with Māori ministers, members of Parliament, officials and national commentators and from the five case study districts.
- The report provides a summary of the interim analysis of data from key informant interviews with Pacific officials and national commentators and from the five case study districts.
- The implementation of *The Primary Health Care Strategy* and formation of Primary Health Organisations (PHOs) has been researched and included in this report only in an introductory manner. This is being studied and reported as a stand-alone topic. The Health Research Council, the Ministry of Health and ACC are funding a separate evaluation on the implementation and intermediate outcomes from the PHCS and consequently, our work on this area will become more limited.
- A separate report on disability support services (DSS) is also included in this report, setting out the current state in relation to responsibilities for monitoring and implementing the NZDS and noting the issues surrounding devolution of DSS funding to DHBs.
- Interviews held with national stakeholders, including national offices of non-government organisations (NGOs) are at a very early stage, but some information from these interviews is included here.
- A separate report is included on needs assessment and prioritisation processes, based on document analysis and interviews with DHB Planning and Funding Managers from 20 of the 21 DHBs.
- Descriptive accounts of the regional collaborative arrangements, including the Shared Service Agencies, the Regional Mental Health Networks and DHBNZ are included in this report. Their roles will be monitored in the coming year as their functions evolve.

An important aspect of the research project is the comparison of the model of health delivery with previous models used in New Zealand. Some preliminary comments on this topic are offered in this interim report, but will be discussed more fully in later reports.

For the interviews, key informants and informants in case study districts were chosen for interview because of their expertise and experience. The selection gave comprehensive coverage of those with knowledge of the targeted aspects. The information these informants gave was thoughtful, credible and insightful.

In this phase of the research, the reactions and responses of people in the sector are observed, commented on and given voice, as they grapple with a dynamic policy environment during the implementation phase of the reforms. The nature and strength of a formative evaluation such as this research is that it allows the evolution of implementation to be captured. The data collection process can be likened to a series of snapshots from which the change process can be documented. The sample of informants is selected not only for being knowledgeable and informed, but also attempts to encompass the diversity of views.

This research process undertaken to date has combined qualitative data, quantitative information, and some data from document analysis and observations. Particularly in relation to data from interviews, we are reporting on the issues and themes identified by those people we have interviewed. As qualitative research, and given some interviews were undertaken specifically in order to elicit issues for follow-up in other streams and phases of the research, it is not appropriate to infer from our report that the issues raised are generalised throughout the sector. Later streams and phases of the research will follow-up on issues raised here and will be triangulated across data sources and sites in order to infer both the range of views and the generalisability of those views.

However, where possible, analysis has been conducted to note consistency between informants and sources of information, as well as between DHBs. Differences across key informants are also noted, in order to identify how different groups view the reforms.

Similarly, differences between DHBs are highlighted, as a major objective of the research is to identify the strengths and weaknesses of different local adaptations. The totality of information is used to record the range of implementation experiences, to identify critical success factors in the reforms and to give commentary on weaknesses. However, there are still further analyses, including document analysis, to be undertaken to triangulate with many of the findings reported here.

In each section, we link our findings with the main source or sources of data. In some cases we talk generically about ‘key informants’ or ‘informants’ rather than identifying the role of those interviewed, in order to maintain confidentiality.

The key themes reported on in this interim report are as follows:

- Governance
 - Becoming a Board member
 - The Board member role
 - Accountability
 - Performance monitoring
 - The strategic focus of Boards
 - The role of statutory committees
 - Capacity and capability of Boards
 - Board processes and procedures
 - Transparency
 - Board-management relationships
 - Board performance
- Strategic decision making
 - Needs assessment, priority setting, planning and budgeting
 - Role of communities
- Implementation of key strategies
- Funding
- Purchasing and contracting
- Treaty of Waitangi and Māori health

- Pacific peoples and Pacific health
- Devolution
- Capacity and capability
- Adaptation of the Ministry of Health to new role
- The NZPHDA model.

In the main body of the report, we focus on these key themes. In reporting on each theme, we include a brief statement of the legislative framework set by the Act and the accompanying policy context, then cover any expectations of the reforms, as gleaned from the initial key informant interviews we undertook in 2001. This is followed by our initial findings, as collated from the survey of Board members, interviews with Board chairs and CEOs, and case study material. The interviews with national stakeholders are at an early stage but some information from these is included here. Issues relating to Treaty of Waitangi and Māori Health and Pacific peoples and Pacific Health themes are, for this Interim Report, discussed separately. Analyses are presented separately by data source, in Appendices to this report. More detailed information on the methods is also included in these Appendices.

In this Interim Report we are not reporting in detail on some topics included in our research. We have yet to collate material relating to the implementation of the New Zealand Health Strategy, as we wish to comment on this following a fuller analysis of DHB documentation, including the 2002/03 annual reports and 2003/04 district annual plans. We have yet to interview key informants in the Ministry of Health about their perspectives of how the Ministry is adapting to its new roles. We have also yet to analyse data collections pertaining to the model's performance, and to devise a framework for comparing performance under the model with performance under previous models of health care system organisation.

5.2 Interpreting Findings

To date, we have largely collected data on people's insights and views of the reforms and their implementation from interviews. Where similar themes are being researched using different research methods and in different DHBs, we are triangulating the data from these different methods and from different DHBs. However, we have yet to analyse fully the data from case study interviews and to triangulate results from each case study district with results from other districts, and we also have yet to triangulate interview data with data from documentary sources and Board observations with interview data from the case studies. This will be undertaken in the few months. We intend to undertake detailed document analysis during the full analysis of case study data, and to triangulate our findings with data from our observations of Board meetings, and an analysis of performance, expenditure and financial data to identify if the insights reported here are supported by other data sources.

Key informants include people who continue to work within the health sector, and some who were leaving the sector. Efforts have been made to ensure a full range of views have been captured.

Different parts of the research have been undertaken at different times. The time line of the research is summarised in Figure 2, including the policy context. The public survey was undertaken in mid-2001; key informant interviews in early-to-mid 2002; the Board member survey in mid-2002; planning and funding manager interviews in mid-2002; CEO interviews from late 2002 to early 2003; while case study information has been collected between October 2002 and May 2003. Circumstances may have changed since we collected our data. Thus, our reporting should not necessarily be considered to be representative of how things are today. An important point to note about the research is that we are particularly interested in how the model develops over time, and whether change in a positive direction is identified between the phases of our research. We will be in a better position at the end of 2004 to identify issues that may be of real concern because they have persisted throughout three years of data collection.

Figure 2: Relating the Timeline for the Research with the Policy Context

1. Data Collected To Date

Note: Letters with date refer to Policy Implementation, according to Policy Context Key below

Date A,B,C, Already Enacted By Apr '01	A p ' 0 1 D	M a y 0 1	J u n 0 1	J u l 0 1 E F K	A u g 0 1	S e p 0 1 G	O c t 0 1	N o v 0 1	D e c 0 1	J a n 0 2	F e b 0 2 J	M a r 0 2	A p r 0 2	M a y 0 2	J u n 0 2	J u l 0 2 E F H K L	A u g 0 2	S e p 0 2	O c t 0 2	N o v 0 2 M	D e c 0 2	J a n 0 3	F e b 0 3	M a r 0 3	A p r 0 3	M a y 0 2	J u n 0 3	J u l 0 3 F I		
Public Opin. survey		*	*																											
Key inform. Interviews											*	*	*	*																
Bd member survey														*	*															
CEO interviews																	*	*	*	*	*	*	*	*						
Case studies															*	*	*	*	*	*	*	*	*	*	*	*				
Funding & Plan. Man.																		*	*	*										
Maori Key Inform. Int.																*	*	*	*	*	*	*	*							
Pacific Key Inform. Int.																*	*	*	*	*	*	*	*							
Disability Serv. paper																*	*	*	*	*	*	*	*	*						
Shared Serv. Agencies																*	*	*	*	*	*	*	*	*						
Reg. Mental Health Paper																					*	*								
Primary Care Strat. Study																*	*	*	*	*	*	*	*							
National Stakeholders																							*	*	*	*	*			
Chairperson interviews																							*	*	*	*				
Health needs Assessment study																		*	*	*										

2. Policy Context Key:

- A. *New Zealand Health Strategy*, published December 2000
- B. *New Zealand Public Health and Disability Act*, published 1 January 2001
- C. *New Zealand Primary Health Care Strategy*, published February 2001
- D. *New Zealand Disability Strategy*, published April 2001
- E. District Strategic Plans, produced as soon as practicable after 1 January 2001
- F. District Annual Plans, produced 1 July, 2001, 2002, 2003
- G. Local Body Elections, Boards elected October 2001
- H. 2002-2003 fiscal year- funding for contracts with providers in local DHB areas.
- I. Population Based Funding Formula: Agreed by Cabinet December 2000, for implementation 2003-2004 fiscal year
- J. *Pacific Health and Disability Action Plan*, published February 2002
- K. Contract funding devolved to DHBs, July 2001, July 2002
- L. First Primary Health Organisation established July 2002
- M. *He Korowai Oranga/The Māori Health Strategy and Whakatātaka/The Māori Health Action Plan*, published November 2002.

6 Interim Findings

6.1 Goals of the Reforms

A number of ministers, ministerial advisors and officials noted the key goal of the reforms is to achieve a sector-wide population focus for health. Taking a population health focus was not well defined, although a number of people identified the key aim of the reforms as a shift of focus away from hospital services to primary and preventative care.

Some noted devolution and community participation as key ends in themselves, and that the reforms aim to change the way the health system is governed, the way the decisions are taken and the people involved in those decision making processes. One key informant stated there was a belief that outcomes could be improved by working more at a local level, but thought this was a leap of faith rather than a proven strategy.

Ministers, ministerial advisors and officials also noted the government wished to open the health system up, ‘warts and all’ in the words of one Minister. This would occur by allowing the media to attend meetings, allowing members of the public to sit in on meetings and to appear before the DHB, putting their views forward. Thus, the model would operate with as much information as possible. The aim is to make the system open and transparent. The comment was made that ‘the public actually can be quite sensible about what’s going on if they don’t think there’s a conspiracy that’s in secret’. This Minister felt that early impressions suggested the DHBs are doing much more in public than occurred with the HFA and RHA models.

Most CEOs recognised the government’s goals as being in two broad areas: a focus on health status and reducing inequalities via the New Zealand Health Strategy, and a system that allows community involvement and accountability through DHBs.

6.2 The Rationale for the Structure Chosen

A key part of the development of the model and its implementation was a move from the HFA, a single purchaser, and 22 HHSs, as publicly-owned providers, to 21 publicly-owned DHBs⁵. We asked key informants to discuss the rationale for 21 DHBs. There were mixed views on this. Ministers, ministerial advisors and some officials noted there was a preference for focusing on issues relating to promoting *health* rather than wasting time engaging in arguments over the number and location of DHBs. Thus the 21 DHBs were established around existing organisations, ie HHSs, in part to reduce the potential political costs of the reforms. Some officials felt this was also a simple way of keeping the financial costs of implementing the new system down as far as possible; expanding the existing hospital management role rather than establishing a new organisation. Some noted that, from a policy perspective, there is a trade-off between obtaining economies of scale and managing risk in order to manage within a budget, favouring larger DHBs, against the closeness of DHBs to a local population, favouring smaller DHBs. New Zealand's social geography is seen as an important issue here, with many geographical boundaries leading to natural communities of interest. However, with few exceptions, e.g. Northland and Tairāwhiti, the boundaries of the DHBs do not coincide with iwi boundaries. Some officials felt the establishment of 21 DHBs was a return to the previous model of hospital boards and AHBs, both of which were based around hospitals. Some suggested this reflected a deep-seated view that hospitals are central to the health care system in New Zealand.

There was recognition from both ministers and officials that 21 DHBs were probably more than would have been chosen if the system were being built from scratch. One official noted there was an inclination to have fewer DHBs, but that would have led to very large areas being covered by single DHBs, where there were different communities of interest and different health care needs (eg in Auckland). It would also require a cumbersome ward structure to support Board elections.

⁵ The original 23 CHEs became 22 HHSs with the amalgamation of Whakatane and Tauranga CHEs into Pacific Health HHS in 1999; 22 HHSs then became 21 DHBs with the amalgamation of the two Christchurch HHSs into one DHB.

Others noted that in addition to encouraging a smoother transition, establishing 21 DHBs and enabling voluntary amalgamations over time was a more sensible approach. Economies of scale could then be encouraged through co-operation between DHBs (and such co-operation would be beneficial in itself).

6.3 Public Perceptions of the Reforms

The public survey indicated that there was wide-spread optimism the DHBs would bring easier access to hospital services, and that they would consult with the public. Medical professionals, local members of the public, Māori, Pacific people and people with physical disabilities were the preferred types of people to be DHB members. Most people agreed that setting budgets and deciding what services should be available, and especially consulting the public, were suitable activities for DHBs. Over three-quarters of the respondents would like to have their say by voting for DHB members, but at the same time, most respondents did not spontaneously suggest DHB members should be the people who make decisions about health services. They saw health professionals as key decision-makers.

Over half (58%) of respondents thought government should spend more on keeping people healthy, while also maintaining hospital spending. There was opposition to increased user charges (79%). Of those who wanted increased primary/preventative services with no reduction in current secondary services, 53% favoured paying for the increase in services by encouraging private health insurance.

At that time the satisfaction with the existing services was poor, with dissatisfaction being higher for Māori. Waiting times and costs were cited as key reasons for dissatisfaction. However those respondents who cited personal experience of the health sector, or that of family and friends, as the main determinant of their response were more likely to be satisfied. Waiting times were of particular concern to respondents.

There was broad agreement with the priority goals of the various health and disability strategies. Reduced waiting times for public hospital treatment was ranked as the highest priority (from a list given to respondents) and the lowest ranking was given to enabling people with psychiatric disabilities to live in the community.

6.4 Governance

6.4.1 Context: Legislative Framework

‘Governance...holds management and the organization accountable for its actions and helps provide management with overall strategic direction’ (Shortell and Kaluzny 1993, p.15).

Under the Act, the Minister of Health is responsible for determining a strategy for health services, (s.8); and the Minister responsible for disability issues must determine a strategy for disability support services (the New Zealand Health Strategy or NZHS and the New Zealand Disability Strategy or NZDS). The DHBs are established as statutory corporations. The DHBs have a number of objectives, as defined in the Act (s.22), to (inter alia) improve, promote and protect the health of people and communities; promote effective care or support for those in need of personal health services or disability support services; promote the inclusion and participation in society and independence of people with disabilities; reduce health disparities by improving health outcomes for Māori and other population groups; and reduce, with a view to eliminating, health outcome disparities between various population groups. DHBs are to foster community participation in health improvement and in planning for the provision of services. DHBs are clearly accountable to the Minister of Health (s. 37). They must develop district strategic plans (DSPs), district annual plans (DAPs) and table statements of intent in Parliament. DSPs must reflect the overall direction set out in, and not be inconsistent with, the NZHS and the NZDS (s.38 (7)).

The Crown funding agreements (s. 10(1)) also enables the Crown to monitor performance (s.10(2c)). This monitoring is delegated to the Ministry (s.10(3)).

A major difference between the current model and the model of the 1990s is that DHBs are to have a majority of governing Board members elected. The Act specifies that each DHB governing Board is to consist of seven elected members, while up to four members can be appointed by the Minister (s.29). The Act decrees there must be at least two Māori members on each Board, and preferably the number of Māori on each Board is to be proportional to the number of Māori in the DHB resident population (s.29). Conflicts of interest must be declared prior to election. Employees of the DHB are eligible for election.

The Act directs DHBs to establish three statutory committees to provide advice to the DHB governing Board. These are the Community and Public Health Advisory Committee (CPHAC), the Disability Support Advisory Committee (DSAC), and the Hospital Advisory Committee (HAC).

One of the purposes of the Act is to provide a community voice in matters relating to personal health, public health and disability support services, by providing for elected members of Boards; providing for Board meetings and certain committee meetings to be open to the public; and providing for consultation on strategic planning (s.3(1)(c)).

In order to recognise and respect the principles of the Treaty of Waitangi, the Act also explicitly provides mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services (s. 4). DHBs must establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement; continue to foster the development of Māori capacity for participating in the sector and for providing for the needs of Māori; and provide relevant information to Māori to meet these ends (s.23 (d), (e), (f)).

6.4.2 Context: Theory and Policy Expectations for Governance

In our key informant interviews, we asked a number of questions about the issues raised by the mix of accountabilities signalled in the legislation. Ministers and officials stressed that ‘...district health boards are very, very clearly accountable to their Minister’. One Minister viewed the DHB accountability to central government as essential, given that the funding comes from central government and given that it is central government that is directing overall health policy. Within this context, it was expected that elected members would represent their district and bring local knowledge into decision-making.

However, a number of those we interviewed, including officials, predicted this mix of accountabilities, and the desire for local decision-making at a local level while DHBs are also being accountable to the Minister, would generate tensions.

A number of key informants, both ministers and officials, also indicated that decision-making would be devolved over time, but they always stressed that this would occur within national frameworks, eg taking into account national strategies and priorities and service coverage frameworks. Some felt that this too would cause conflict between local, regional, and national decision-making processes, and some officials felt that decision-making would be dominated by national priorities.

It was also argued by ministers and officials that the phased hand-over was intended to give the DHBs time to establish capacity and capability, and to protect health funding and provision as capacity and capability developed in DHBs.

A number of officials discussed the background to the DHB Statutory Committees. They noted that once it was decided that DHBs would own public hospitals, it was suggested that there should be a Hospital Advisory Committee (HAC) to maintain a separate focus on the proper management of hospital assets. However some central government policy makers were then concerned that this overly weighted focus back on to the secondary and tertiary sector, when a strategic re-orientation to population health was desired. Therefore

the Community and Public Health Advisory Committee (CPHAC) was introduced as a counter-balance to HAC, even though some officials felt the broader community focus was in fact the role of the DHB Board. This was followed by a desire for the Disability Support Advisory Committee (DSAC).

One key informant raised a concern around the accountability arrangements. If DHBs did not have the scope of budget and responsibility for a reasonable range of service, then it would be impossible to hold them to account for anything. They would simply be able to argue that what they were doing was influenced by a whole range of constraints. This key informant noted that if New Zealand was going this far to develop a devolved model, then we should go ‘the whole hog and devolve responsibility to DHBs’.

A number of key informants noted that performance in the health sector is difficult to manage, and that the available instruments are seen as being very blunt. An official stated the Ministry uses the organisational performance as a proxy for the performance of Board members. Where there are concerns, the Ministry has used monitoring, then escalating reporting requirements. Officials are aware that ideally a good performance management framework rewards good people and good DHBs, but there is a risk of perverse incentives if, for example, poor performance resulting in a big deficit is rewarded with a big equity injection.

Key informants noted the tools that are available to manage DHBs and promote good performance: giving DHBs their payments at the beginning of the month so the DHBs can earn and retain the interest on the funding; publishing data on DHB performance; and bringing well-performing DHBs into forums with those who are not performing well, to discuss ways of improving outcomes across the sector.

6.4.3 Findings: Governance

Becoming a Board Member

All key informants acknowledged that involving local communities in decision-making is of central importance in the model. However, some suggested that the electoral process does not always provide good representation or guarantee local participation in decision-making. Some officials expressed surprise that so many people stood for election, and noted that this did seem to vindicate the reforms and the model chosen, even if elector turnout was viewed as relatively modest.

Ministers and officials we interviewed expressed concern at the low numbers of Māori elected to Boards and concern that no Pacific members were elected. A number of people felt that a single transferable vote system would give better representation in future elections (although the reasons for this were not discussed), but they noted that it had not been feasible to establish such a system in time for the 2001 elections.

Following the elections, a final analysis of Board composition by officials permitted the Minister to make appointments, mindful of the skills and experience that were considered needed on DHB governing Boards; this included Māori and Pacific skills and experience. Although the appointment process allowed gaps in representation to be addressed, in our interviews, Chairs of Boards expressed a desire for greater input into the appointment process. Māori key informants also raised issues about this, with some iwi representatives expressing frustration at the lack of transparency, at the Ministerial level, about the process for appointing Board members, after the iwis' nominations have been forwarded to government.

One key informant expressed concern that although the legislation requires candidates to declare conflicts of interest, nobody checks to see whether this is done, and nobody has the responsibility to ask someone to stand down if there are ‘too many’ conflicts of interest. Generally it is left to the public to make the assessment. This informant considered that there are a number of people with significant conflicts of interest on Boards, and suggested media might provide more information on possible conflicts to inform the public.

The Board survey respondents had the following characteristics⁶:

- Sixty-five percent (n=97) of respondent Board members were elected, a further eleven (0.08%) were elected and appointed⁷, and nearly 27% percent (n=40) of respondents appointed to Boards.
- Just under 70% of respondent members became Board members following the October 2001 elections; just under 28% were members prior to the elections. 45% of the appointed respondent Board members were members prior to the 2001 elections compared with 15.6% of elected members; 78.6% of those who were members following the elections, were elected members.
- Of those respondents elected to Boards, 99 were non-Māori; 9 were Māori. Of those respondents appointed to Boards, 15 were Māori. Of the Māori (including those who defined themselves as “Māori only” and also those who indicated “some” Māori ethnicity) responding to the survey, 65.2% were appointed as compared to 34.8% elected. These survey results regarding Māori representation will be compared to Ministry figures in the next round of data collection.
- No Pacific people responding to the survey were elected; 1 Cook Island Māori and 1 Samoan were appointed to Boards.

⁶ The survey of Board members elicited a 66% response rate with 144 returned from the 217 sent out. A comparison will be made in the final Survey report between the characteristics of DHB Board members as recorded by the Ministry, and those responding to the Survey.

⁷ Those both elected and appointed are likely to be Chairs of Board, elected by their communities and subsequently appointed Chair by the Minister of Health.

In the survey, DHB Board members gave mixed views as to whether they felt adequately informed about relevant issues prior to election or appointment (relevant issues were not defined; this was left up to respondents to determine). Forty-five percent agreed or strongly agreed that they felt informed prior to election or appointment, compared with almost 30% who disagreed or strongly disagreed with the statement that they were well informed.

Case study informants observed that although elected members can improve the breadth of decision-making, by contributing a wide range of skill and expertise, the electoral process can leave Boards with a poor mix of skills, gaps in expertise, members with variable abilities, and an imbalance of sector interests. The importance of government being able to fill these gaps and offset any imbalances with appointed members was stressed by some informants.

The prospect of good elected members being voted off the Board and consequent loss of competency, expertise and institutional knowledge was raised as a concern in one case study Board, and by CEOs; there was a perception in one DHB that elected members who are also staff can be a barrier to progress; and in another DHB it was felt that the Ministry should not have anything to do with appointing Board members.

The Board Member Role

Officials we interviewed noted there was a training programme for new Board members, with one day spent on governance and a second day with a health focus. It was noted that it was difficult to fit in sufficient training in this limited time. Case study informants confirmed that training has helped foster a better understanding of the governance role for both Board members and DHB employees.

In the Board member survey, 40.9% of respondents agreed or strongly agreed that they would like more training, while almost 30% disagreed or strongly disagreed. The remainder neither agreed nor disagreed with this statement.

In relation to other survey questions on their roles, most Board member respondents felt they bring “added value” to decisions (73.9%) and most (87.2%) felt that they have a clear understanding of their role as a Board member, although elected members were less likely to agree on this point than appointed members. Many also agreed or strongly agreed that they are able to influence Board decisions, although again elected members were less likely to agree.

Most Board member respondents (87.3%) agreed that they have a good grasp of the issues, and almost all (93.3%) agreed that they would ask for more information if they did not understand an issue. Almost a third of respondents neither disagreed nor agreed that they find their workload as a member to be excessive, whereas 42.9% disagreed or strongly disagreed (that the workload is excessive), but 25.5% agreed or strongly agreed with this statement. Nearly two-thirds of respondent members, at the time of the survey, agreed or strongly agreed that they would probably choose to stay on another term, whereas 12.7% disagreed or strongly disagreed.

The survey of members also indicated that just over half of Board members considered they had the right information for decision-making, and most (87.3%) Board members agreed or strongly agreed they receive regular, adequate reports on the financial position of the Board and on service performance. However there were mixed views as to whether Board members felt they were able to monitor service quality through provider contracts. There were also mixed responses to the statement that the ‘real’ work and decision-making of the Board takes place outside formal Board or Committee meetings.

Some CEOs commented on the Board members who are also employees (in the survey, just over 5% of respondent Board members were in this category). Those who raised this issue acknowledged the definite potential for conflict of interest. Whether or not this became a problem was dependent on the attitude of the member, according to these CEOs. Some noted the importance of clarifying roles and relationships, e.g. ‘In Board meetings I treat them as my employer’. Overall the presence of employees was regarded as a problem to be managed, rather than a major issue with the legislation.

CEOs observed that many Board members have found the governance role difficult to understand, though clarity has improved over time. Some CEOs noted a division between elected and appointed members, whereas others reported all worked well together.

A range of experiences have been identified in the case study DHBs. One DHB reported a lack of governance experience. Some DHBs have found governance a difficult concept to understand and put into practice. Demarcation problems between Board members and managers were reported in some DHBs with reports of Board members interfering at management level and managers not understanding the role of governance. In one DHB it was noted that the Board sometimes gets involved in operational issues; in several DHBs, it was suggested that governance/management roles should not be seen as divided by a ‘clear line in the sand’ and that a pragmatic approach is needed. In one DHB, the Chair is seen to be very clear on the distinction between governance and management and communicates this to the Board through governance seminars and the use of a handbook. In another, the governance role is seen as evolving, and there is still ‘a way to go’ to achieve effective governance, but signs are that the organisation is moving on and maturing in this area. In two DHBs, there have been joint Board member/management training in governance, and this was seen as positive.

Accountability

The survey of Board members indicated there were mixed views as to whether Board members see their primary accountability being to government or to local communities. Elected members acknowledged dual accountability to the community and to the Minister, with 55.4% of elected members feeling able to handle this dual accountability; 20% disagreed or strongly disagreed they were able to handle this dual accountability. For appointed members, 58.4% felt principally accountable to the Minister; 18.7% disagreed or strongly disagreed that they feel principally accountable to the Minister of Health. One-half of respondents disagreed that accountability to whānau/hapu/iwi is a source of tension, while almost a third of Māori respondents found accountability to whānau/hapu/iwi a source of tension for them.

Some respondents see their role as representing a local geographical area (53.6%), and there were mixed views as to whether respondents see part of their role as representing the interests of one or more special groups in the community. Māori Board members were more likely to see their role as representing interests of one or more special groups in the community.

The survey of Board members indicated that just under half of respondents agree or strongly agree that the Board has adequate autonomy; 20% disagreed or strongly disagreed. Elected Board member respondents were less likely to agree that their Board has adequate autonomy. Māori Board member respondents were more likely to agree that the Board has adequate autonomy. Just over sixty-one percent of Board member respondents also agreed or strongly agreed with the statement that there are times when the Ministry and Government interfere inappropriately in the work of the DHB. At the same time, 59% of Board member respondents indicated that there should be more support from the Ministry and Government for the DHBs (although from the Likert scale questions, it is not clear what form this support might take).

All CEOs indicated that elected members had a strong sense of accountability to the community, with many ‘struggling’ to see their primary accountability to the Minister. Elected members were more likely to be ‘loose cannons.’ CEOs reported that as time went on strategies for dealing with this had been developed, including leadership from Chairs; being proactive about contentious issues; seeking to involve the Minister and Ministry; and having appointed members fully acknowledge the tension for elected colleagues. In instances where the CEO felt it had not been a major issue there were indications that this was due to: the role of chair; appointed members recognising the dilemma for elected members and supporting them; and the high level of skill and competence in some elected members. Some CEOs felt that this would be a persistent issue as elections came around.

Some CEOs also noted that despite the variability of Board member backgrounds and skills, Board relationships were good, with good teamwork emerging.

Data from the case studies showed similar trends as reported by CEOs. In one Board, tensions are visible in the behaviour of elected members: some members are observed as finding their role difficult regarding where their allegiance lies, and to whom they are accountable. Dilemmas can arise when there is a conflict between advice from their constituents and other sources of advice. Similar comments were made in another DHB on the differences in the way different members consider issues at the Board table. In one DHB it was noted, however, that appointed members also have ‘constituencies’. Dual accountability is recognised as a reality in one DHB.

The case study data also showed there are dilemmas for elected members wanting to contribute but having to abide by collective accountability, and this is seen as possibly working against aspirations for election. Although there is an understanding and empathy for this position, it does not sit well with the requirements of the Act.

Performance Monitoring

In the Board member survey, only half of the respondents agreed or strongly agreed that they understand how their Board's performance is being assessed. Nearly two-thirds considered the Board's main imperative was to stay within budget or reduce the deficit.

In three case study DHBs, it was felt that the amount of time spent on addressing performance monitoring is onerous and the amount of information requested too detailed, tying up DHB staff for far too long. In one DHB the comment was made that the dollars soaked up in this way could be used for 'core business' and also that the Ministry are 'intrusive in their control of DHB business' through performance monitoring.

The Strategic Focus of Boards

In the Board member survey, most respondents agreed that Government strategy plays an important part in Board decision-making. The issues identified by Board members as personally most important to them largely coincided with the various Strategies adopted by government. These included: improved health status in the community; quality health services; tackling high priority public health issues; reduced health inequalities and improved health status for all disadvantaged groups; independence and inclusion in society for people with disabilities; and better access to services. Other issues were rated as of slightly lesser importance: recognising the importance of the Treaty of Waitangi in health sector decision-making, and DHBs being environmentally responsible.

The issues perceived by respondent Board members to be of most importance to their DHB included quality health services, improved health status in the community, reduced health inequalities and improved health status for Māori, recognising the importance of the Treaty of Waitangi in health sector decision-making, and tackling high priority public health issues.

Of least importance were DHBs being environmentally responsible, and reduced health inequalities and improved health status for Pacific peoples (although these still had relatively high scores).

Significant progress was expected by respondent Board members over the next two-to-three years especially in relation to: tackling high priority public health issues; giving greater priority to primary care; recognising the importance of the Treaty of Waitangi in health sector decision-making; integration of primary and secondary care services; involvement of the community in health sector decision-making, and quality health services. Less progress was expected in relation to reduced waiting times for services, and reduced health inequalities and improved health status for Pacific peoples.

Board members from the seven DHBs with a high proportion of Pacific peoples did not rate 'reduced health inequalities and improved health status for Pacific peoples' as of a higher importance than other goals. This applied to all three questions on this issue, ie personal perspectives, importance to the DHB and expected progress over the next two-to-three years.

Most Board members feel they provide a clear vision for local health developments. Many respondents (59.8%) felt their Board spent enough time on policy and strategic planning. There were, however, mixed responses as to whether Board discussion is dominated by hospital issues.

Most CEOs reported that the level of strategic leadership demonstrated by Boards was relatively limited, with a need to raise the overall level of debate on issues. Several CEOs noted an over-reliance on management that they were concerned might lead to too narrow a focus and even resentment at management 'dominance'.

Nearly all CEOs acknowledged that Boards had worked hard on their strategic plans under very difficult circumstances and time pressures. Boards were able to reach agreement and some members became involved in community consultation. The strong direction from government had meant that there were not many opportunities to demonstrate local leadership.

In one case study DHB, there is a perception that business decisions may be less robust with elected members, as they tend to be ‘clouded by more emotion’ than when there is a totally appointed Board. Appointed Board members tended to ask ‘what is good for the organisation’, whereas there could be more emotion in decision-making with an elected Board. In another DHB, it was noted that some elected Board members tend to have a narrow focus on particular services rather than a broader strategic perspective.

Some case study informants (not Board members or employees) commented that, despite the rhetoric of the DHB’s strategic plan, their current focus remains firmly on hospitals and the deficit, rather than on development of services and health outcomes.

The Role of Statutory Committees

The survey of Board members showed that the majority of respondents (73.2%) considered the Board committees play a significant role in the work of the DHB overall. Informants in several case study DHBs reported that much of the debate and decision-making occurs at the committee level rather than at full Board meetings. However it was also noted by informants that it was important that the Committees should not operate independently of the Board.

A strong majority of CEOs reported that the governance structure, with three mandatory committees, is excessive. The HAC was seen as filling an important role. However, both DSAC and CPHAC were reported to have little meaningful work once DHB Strategic Plans were completed. Overall the costs of servicing the committees were considered

greater than the benefits accrued. A few CEOs reported the committees were useful. For example, one CEO reported the committees were useful for actively structuring community involvement (by drawing in people from the community with desired knowledge and skills); another found it valuable to have all issues fully discussed at committee prior to a Board meeting.

Case study data shows that Boards have adapted committee structures. Thus, for example, one Board has in effect combined their CPHAC and HAC. Both committees have the same membership and meetings are held on the same day. The original two committee chairs (both Board members) have been retained and the chair role is split between these two people. The rationale given for this is that the provider arm should be treated the same way as other providers in terms of purchasing services if the DHB is to refocus from a hospital orientation to a health DHB. Case study informants were generally of the opinion that this system seems to be working well. Some outsiders were critical of the DHB's focus on hospitals and the deficit rather than on development of services and health outcomes.

Additional committees have also been established in DHBs. These include finance and/or audit committees, site or facility development committees, human resources or remuneration committees, quality and risk management committees, and funding management committees. Finance or funding committees are perceived in one DHB as the most powerful of the committees as they consider all the resource implications of other committees' recommendations.

DSACs generally report being frustrated at being in a "hiatus" at present, with hope that they will become very useful once disability funding has been devolved. One DSAC has developed a DHB Disability Action Plan (in line with its responsibilities under the New Zealand Disability Strategy); others are keen to take up their tasks once funding for disability support services is devolved. CPHAC at one DHB reported its main function had been in a governance role during the development of the strategic plan but that it has struggled with its role and the need to become community oriented. One CPHAC has

combined with Māori interests and initiated special public forums. Another sometimes uses the committee time to conduct small group working sessions on specific strategic issues, with any public attendees being invited to participate.

HAC in one DHB is perceived as a significant and powerful committee, with monitoring control over a substantial part of the DHB's expenditure. Its work appears to be 'business as usual' continuing from the CHE model. It too in this DHB is slowly coming to terms with its new role.

Several DHBs report that much of the debate and decision-making occurs at the committee level rather than at full Board meetings.

The Statutory Committees are reported by almost all the case study DHBs to be very costly to support from an administrative and management perspective, to take a large amount of time in support, and to be a complication to governance-management-operations boundaries. In one DHB, the workload of CPHAC was linked with strategic planning processes, and this required a significant amount of work. To others, there is a lack of clarity over the committee roles.

Capacity and Capability of Boards

CEOs reported that elected members tended to lack technical skills, particularly financial skills and depth of knowledge of the health sector. Some CEOs were concerned about this, as it was perceived that the Board could not effectively challenge management. One CEO stated 'I feel quite exposed.' The community knowledge and networks of elected members were highly valued by CEOs. Overall, CEOs were grateful for the presence of appointed members.

There was a general consensus from CEOs that, despite the teething troubles and initial lack of capacity, Boards are performing well and are becoming more strategic over time.

However it is also felt that major input (in the form of training, workshops, and leadership from the Chair) has been necessary to achieve this. There is concern that this investment of effort will be lost if there is a high turnover at the next election. Case study informants also expressed concern at the prospect of good elected Board members being voted off the Board and consequent loss of competency, expertise and institutional knowledge.

The need for more financial/business expertise on Boards was expressed in several case study DHBs. In one DHB, it was felt that the Ministry training for Board members was good, but it would be more useful if it came from successful Board members sharing their past experience.

As noted above, in one case study DHB, there is a perception that business decisions may be less robust with elected members, as they tend to be 'clouded by more emotion' than when there is a totally appointed Board. Appointed Board members tended to ask 'what is good for the organisation', whereas there could be more emotion in decision-making with an elected Board. In another DHB, it was noted that some elected Board members tend to have a narrow focus on particular services rather than a broader strategic perspective.

Board Processes and Procedures

The survey of Board members indicated that many respondent Board members (73.9%) agreed that diverse points of view are valued, that conflicts of interest are handled well (73%), and that Board meetings are run efficiently and well. Many (68.5%) felt that Board members are working well together. Just under half agreed that there is adequate time for discussion of major issues.

Some CEOs observed divisions between elected and appointed members and the potential for the development of factions. Others reported that in their Boards there were no divisions and all members worked well and together.

Some CEOs also noted potential conflicts of interest, for example, with employees as Board members. However, this was seen as something that, largely, could be managed rather than being a major issue. Overall CEOs reported that Board processes and procedures were handled well and many paid strong tribute to Chairs, as carrying out a difficult job well.

One case study DHB reported personality tensions and ‘bickering’ at meetings. In this DHB, members who were unhappy with decisions tended to revisit the issue at later meetings, creating difficulties. Workshops are used to try and resolve differences.

Transparency

Most CEOs acknowledged the centrality of community involvement in the legislation. Some found open meetings as helpful in managing community expectations and allowing a more positive engagement with the media. Interviews with CEOs also suggested that the governance system of elected members and open meetings was not seen as contributing as much to community involvement compared with the more structured processes many DHBs had used for their strategic planning. Taking meetings “on the road” to more remote areas had been used successfully in some DHBs to fulfil the spirit of transparency.

Some negative points relating to open meetings were noted by CEOs. Public meetings were seen to constrain the debate necessary for good decision-making, due to the time available and members not wishing to be exposed through the frankness of discussion. Some DHBs use informal workshops and closed parts of Board meetings as mechanisms to cope with this.

Although Board meetings are open, researchers have observed that, with notable exceptions, few members of the public attend Board meetings apart from themselves and, in some cases, the media representatives. Data from the case studies suggest that those that attend are seen to frequently have a particular agenda item that is of concern to them. Some Boards invite participation in discussions, others allow the public only as observers, or require formal notice of motion in order for public to speak. Committee meetings are also open to the public. Though Boards report trying to hold more business in public, there are difficulties if Board members discuss confidential issues at public meetings. In one Board it was reported that decision-making was slower in committees because of members of the public being present, where Board members feel the need to give reasoning for their points of view and to reiterate their values base. Boards continue to use ‘public excluded’ times at meetings.

Board-Management Relationships

In the Board member survey, almost 60% of respondents agreed with the statement that Board and management share a common vision. Just over half of the Board members strongly disagreed or disagreed that they were “a rubber stamp for management,” but just over a quarter concurred with this view.

In the key informant interviews, a number of officials indicated there had been concern that Board members would not make an adequate distinction between the roles of the Board and those of management. Consequently, governance issues were included in the initial training for Board members. Under the model, Board members are not directors (as in a corporate Board) but are stewards of the roles, responsibilities and resources of the DHBs.

In the survey of Board members, there were mixed views about whether the Board has had to become involved in management issues, with a quarter of respondents agreeing or strongly agreeing that they have had to become involved. In response to a more general statement ‘I believe there are times when the Board needs to be involved in “management”

matters’, just under half of the survey respondents disagreed or strongly disagreed; while almost forty percent agreed. Elected Board members were more likely to agree. In the CEO interviews, most commented that there had been difficulties in maintaining proper boundaries between governance and management, though this had improved as members understood their role better. Strategies developed to deal with this included formal education of Boards, the chair working with members, a letter from the CEO explaining roles or an informal chat with members.

Several CEOs advocated open communication, flexibility, and building working relationships as the keys to boundary issues. Case study informants endorsed the significance of personalities and successful relationships between the Board Chair and the CEO in facilitating governance.

Board Performance

In the Board member survey, many respondents (just under two-thirds) agreed that their Board is performing very effectively. Most CEOs reported progress and improved performance of Boards overall, but also noted that major input had been required to achieve the levels attained (workshops, Board training, and inputs by chairs were acknowledged as significant). They also expressed concern about likely membership turnover at election time.

In one case study DHB it was noted that there is a strong sense that the model is evolving over time. In another, it was noted it was too early to say if the reforms were ‘working’, but almost all those interviewed felt that the model built positively on the reforms of the past. Time was now needed to bed the reforms in and ‘fine tune’ where necessary. In another DHB it was felt that DHBs are still on a learning curve, and it is still too early to comment on performance.

6.5 Strategic Decision-Making

6.5.1 Context: The Legislative Framework, Theory and Policy Expectations for Strategic Decision-Making

The Minister of Health and the Minister responsible for disability issues are responsible under the Act for the over-arching New Zealand Health Strategy (NZHS) and New Zealand Disability Strategy (NZDS) to provide the framework for the Government's overall health sector direction in improving the health of people and communities and for disability support services (s. 8). The Health Needs Assessments (HNAs) are to be used to inform District Strategic Plans (DSPs) (s. 38). Community consultation on the draft DSP is mandatory under the Act (s.38, (3c)). The DSP states the objectives of the DHB for the five to ten year period from the time of determination, and are to be made publicly available, as are any amendments. These plans are to be reviewed at least once every three years.

Health needs assessment is defined as 'the assessment of the population's capacity to benefit from healthcare services prioritised according to effectiveness, including cost-effectiveness, and funded within available resource' (Coster 2000).

In our interviews with ministers and officials, it was expected that the HNAs would allow Boards to justify their prioritisation of services to the Ministry. It was recognised that the health goals set by the NZHS may not be as relevant in some DHBs as other identified local health needs. It was therefore expected that the HNA process would give the evidence base to justify DHB strategic decision-making.

6.5.2 Findings: Strategic Decision-Making

Needs Assessment, Priority Setting, Planning and Budgeting

Research on DHB HNAs, priority setting and planning processes has been undertaken by Gregor Coster, who was a member of the Research Team until February 2003. This research is based on document analysis and interviews with the DHB Planning and Funding Managers. Interim analyses suggest the following conclusions.

In general the DHB HNAs met the minimum requirements of the Ministry, although there was considerable variation in scope and quality of HNAs in DHBs. The degree of engagement with, and participation by, Māori varied considerably, from no consultation with Māori groups to full consultation. In retrospect, a number of DHBs stated they would have preferred to engage with Māori 'earlier and better'. Community consultation during the HNAs also varied considerably.

Almost without exception, DHBs found difficulty in obtaining and validating data. Data most difficult to obtain were those from primary care and mental health services. Every DHB also commented on the poor quality of data specifying ethnicity, especially from community sources.

Most DHBs found the time frames for completion of the HNAs tight. Most found the workload huge, putting on additional personnel to resource the project in order to meet Ministry of Health deadlines.

Most DHBs found the process and outcomes of the HNAs a valuable exercise. HNAs were seen to provide a solid base of information on which to plan health service delivery. Almost every DHB saw the HNA as a means of reviewing progress of the DHB.

The approach to prioritisation by DHBs also varied considerably, particularly in regard to the amount of involvement of the local community. Most DHBs based their prioritisation frameworks on the HFA model, modified to allow for recognition of the 13 population health objectives set out in the NZHS.

Funding management committees held the real power for decision-making in a number of DHBs. These consist of the CEO, a small number of key managers and sometimes the Chair, and they determined the final shape of annual plans. Minutes are not in the public domain, if they are taken. Recommendations from these committees were then sent to Boards for ratification.

Government Strategies, particularly the NZHS, were a powerful force for all DHBs in the prioritisation process. DHBs received service level requirements from the Ministry, setting out the Ministry's expectations regarding levels of health service provision. Some DHBs endeavoured to manage deficits downwards by reducing access to services and were promptly told this could not be done. In the end, almost all DHBs saw prioritisation as applying to new money, and all stated that over 99% of their budgets were pre-determined by existing contracts with health providers. In terms of being able to allocate resources based on local needs and values, DHBs commented that some contracts had long lead times to completion (eg with contracts having three year terms), and they were generally not prepared to terminate contracts prematurely unless there were performance issues.

Key influences on District Strategic Plans (DSPs) were: legislation, Ministry guidelines, historical factors, HNAs, community feedback regarding preferences, and the financial constraints of the funding environment, including DHB deficits. Government Strategies and the 13 priority population objectives strongly determined the direction of DSPs, which required sign off by the Ministry. DHBs received strong messages that the Government's priority objectives had to be reflected in DSPs, and it appears that this was an overwhelming influence on decision-making.

Although there were good connections between HNAs and priorities, the connections between DSPs and DAPs were not as obvious, possibly because in a number of DHBs the DSPs were written in parallel or subsequently to DAPs. Characteristics of DHBs with strong connections between the HNA, priorities, DSP, DAP and budgeting were: timing; planning processes; stakeholder involvement (often in service planning groups, including community); and planning team expertise. Size was not related to success in the process; nor was size of deficit as a proportion of total budget.

We have also sought information on planning processes from case study districts. Needs-assessment exercises proved useful in the development of the strategic plans. In one DHB, internal analysts produced a lengthy report on the role of DHBs in prioritisation processes. The funding team of one DHB experimented with a principles-based scoring system and the priority-ranking of all contracts in order to advise the Board on options for managing a projected \$2m deficit in the funding arm. The process gave some useful indication about where dis-investment might occur (which is critical, given the need to reduce deficits). However reducing the level of service provision proved politically unacceptable and the Board was directed not to reduce particular services. The general conclusion of this Board was that any further development of a prioritisation process should be undertaken at the national level, given that DHBs have limited resources, many prioritisation decisions are applicable to all DHBs, and many prioritisation decisions are already made at the national level (including decisions which relate only to local services).

Reported barriers to effective decision-making have been: unclear boundaries of responsibilities between the Ministry and the DHBs; inconsistent messages and requirements coming from the Ministry, such as the requirement to carry out prioritisation when health priorities have already been set in the national strategies; political interference; lack of resources (especially time and skills); and inadequate information, especially poor information on existing contracts. In one DHB it was acknowledged that the planning process was jumbled, through time pressures.

Case study informants indicated that prioritisation and planning were largely driven by Ministry requirements and directives. There was not much opportunity to demonstrate local leadership because of the priority objectives of national health strategies, service coverage specifications and deficit reduction requirements. Historical spending was also a determinant of spending. Therefore, the already committed spending left little space for marginal or discretionary spending. Another barrier to effective decision-making was the poor information on existing contracts.

Role of Communities

In the Board survey, many Board members (71.8% of survey respondents) felt they had established procedures for seeking community input. Most (83.3%) felt they had established procedures for seeking input from whānau, hapu, iwi and Māori communities although Māori were less likely to agree (the difference was statistically significant, p.0.02). There are mixed views as to whether Boards have effective ways of reporting to the community on their work.

CEOs observed that community consultation has both advantages and disadvantages. There is a greater responsiveness to community health issues through elected Boards, HNAs, and community consultation. However input tends to come from only a small group of organisations/people. Consultation requires time and commitment to be done well. Some CEOs also regard the more structured processes used as part of strategic planning to be a better way of involving the community than elected Boards and open meetings.

Community and consumer involvement is one of the ten top objectives in the strategic plan of one case study DHB and both the Board and senior management are making concerted efforts to achieve this objective. Community stakeholders saw this Board's efforts to consult with communities as genuine consultation, not just lip-service to a statutory requirement. However, some providers in this district see consultation more as one-sided, with the DHB simply sharing its plans with providers.

Another DHB refers to ‘engagement’ with consumers rather than consultation and uses a variety of methods including working parties on service issues using paid community representatives. Some communities in this district reported feeling over-consulted. This DHB was attempting to discuss more business in public, but noted some difficulties where, for example, Board members start discussing confidential business in an open meeting.

At one DHB respondents generally noted the exercises in community consultation have been worthwhile. However one Board Chair noted that the consultation process is ‘all very well but in the end the Board has to make the final decisions and be accountable for them’.

As noted above, statutory committee meetings are open to the public. In one case study DHB, these meetings sometimes attract significant numbers of people. Though DHB informants report trying to hold more business in public, rather than closing parts of meetings off, there are difficulties if Board members discuss confidential issues at public meetings and, having the public present is said to slow down decision making processes. Boards continue to use ‘public excluded’ times at meetings.

Also as noted above, Board observations indicate that, although Board meetings are open, public attendance is very low in most areas, although in one case study DHB, few people attend Board meetings but CPHACs are more popular. Those that attend frequently have a particular agenda item that is of concern to them. Some Boards invite participation in discussion, whereas other Boards allow the public only as observers, or on formal notice of motion.

6.6 Implementation of Key Strategies

6.6.1 Context: Legislative Framework

The Act charges the Minister of Health to determine the strategy for the health services, to provide the framework for the Government's overall direction of the health sector, called the New Zealand Health Strategy (s.8(1)). The Minister responsible for disability issues must determine a strategy for disability support services, called the New Zealand Disability Strategy (s.8(2)). The relevant Ministers must report on progress in implementing the strategies each year (s.8(4)).

6.6.2 Context: Policy Expectations of New Zealand Health Strategy

Ministers and officials noted the importance of the NZHS in the reformed health sector. It was seen as setting out the strategic direction and framework for the whole of the health sector, and is seen by some as having a powerful place in the sector, given it is mandated under the Act. The NZHS was seen as signalling a change from the previous focus on disease management, towards a more preventative approach incorporating population health goals and service priority objectives. The NZHS determines 13 population health objectives, which have been identified as those where there is the most potential to make health improvements. Toolkits were then developed to provide information to DHBs to help them translate the Strategy into action in their district.

As noted above, ministers and officials expected the HNAs to give the DHBs the evidence base to justify the fine-tuning of national priorities to local needs and concerns. However, one official noted that they 'hope that DHBs would be given the freedom to use the results of the HNAs' once they become 'more mature', signalling that national priorities may dominate planning in the short term.

Officials in the Ministry monitoring DHB strategic and annual plans looked for reflection and inclusion of the NZHS in DHB plans, including around consultation processes, prioritisation processes and for signals of a shift in mind-set from a hospital to a population health perspective.

The implementation of the New Zealand Health Strategy will be commented on later in the research process, following a fuller analysis of Ministry and DHB documentation, including the 2002/03 annual reports and 2003/04 district annual plans.

6.6.3 Context: Policy Expectations of the New Zealand Disability Strategy

Although the Ministry of Health developed the New Zealand Disability Strategy (NZDS), the Office of Disability Issues within the Ministry of Social Development now has taken over responsibility for the NZDS. This change occurred because of a philosophy that disability support services are not primarily health concerns. Ministers and officials reported views that people with disabilities do not believe they are sick, nor do they see themselves as part of the health system. However, people with disabilities may be consumers of health services.

Following delays in policy decision-making, the funding for younger people's services and those for over 65s is now split. According to government officials, the needs of the older group are considered to be predominantly health-related, with funding devolved to DHBs in October 2003. The needs of the younger group are viewed as broader than health alone, related to lifelong disability. It is considered that DHBs may not be the most appropriate agency to be responsible for delivering support for this group. Funding for younger people will remain within the Ministry at least until 2004. At that time a decision will be made as to the most appropriate administrator of funds.

According to the officials we interviewed, the devolution of funds for those with disabilities aged 65 and over is subject to the DHBs proving themselves capable. This includes assessing the generic capacity to take on funding, the capacity to handle contracts, and understanding the need for an integrated continuum of care. It also depends on DHBs actively planning to implement *The Health of Older People Strategy* (Dyson, 2002). It is noted that previous devolutions were not linked to demonstrating capability, with one DHB informant pointing out that managing contracts and provider relations are core functions of the DHB.

As a result of decisions on devolution of disability support services not having occurred until recently, the role of the DSACs has been unclear. DSACs have had an interim role providing advice to their DHB on the needs of disabled people within their population. This role will be expanded as the funds are devolved. Not surprisingly, CEOs reflected this evolutionary process with comments that DSAC has had little purpose beyond contributing to the strategic plan. Even without devolution of funding, DSACs do have a role providing advice on the health needs of people with disabilities – the DHBs have a responsibility for delivering on the Disability Strategy as a provider of services and as an employer – but there is a lack of clarity on this for some DHBs.

Officials and providers recognise that the anticipated devolution of funding for older people's disability support services may:

- create difficulties for providers serving more than one DHB
- create problems where providers deliver services to both older and younger aged groups
- raise issues in relation to consistency across DHBs in services for those 65 and over
- cause problems relating to the transfer of care when people turn 65.

However at least one DHB informant points out this is no different to other devolutions and these possibilities should not be used to justify delays in devolution.

6.6.4 Findings: The New Zealand Disability Strategy

The New Zealand Disability Strategy (NZDS), 'Making a World of Difference: Whakanui Oranga' was released in 2001. The Disability Issues Directorate in the Ministry had responsibility for developing the NZDS. However the Ministry no longer has responsibility for disability issues; this role was transferred to the Office of Disability Issues within the Ministry of Social Development, from September 2002.

DHBs have responsibilities for delivering on the Disability Strategy as a provider of services and as an employer. Because the Disability Strategy is a whole-of-government approach, DHBs are required to demonstrate, as are all Government departments, they are providing services that reflect the strategy. Therefore the DHBs have an obligation to provide services that are accessible to people with disabilities. Also DHBs have a duty as an employer to make sure they comply with the Disability Strategy.

Funding for DSS was not devolved to DHBs with personal and mental health funding in 2001. Until October 2001, the Ministry of Health contracted with providers of disability support services. DHBs do provide some disability support services, but these are limited, including for example Acute Transfer and Rehabilitation (AT & R), wheelchairs and child development services. Most disability support services are provided by community providers, for example, the IHC or CCS.

The decision against devolution of DSS funding arose from nervousness of both providers and consumers in the disability sector as to whether DHBs were the appropriate organisations to manage the funds. This was based partly on a concern that DHB deficits would swallow up disability support services funding. As well as this, there was concern about 21 different approaches and that DHBs were not the right place for disability support services funding since disability issues, particularly in younger people, are often not health related.

The decision was made to split DSS funding into two based on age, according to whether consumers are under 65 or 65 and over. This decision was made because of the differing needs of these groups. The needs of the majority of people with disabilities who are 65 and over are health related, whereas younger people, who tend to have lifelong disabilities, have needs which are much broader than health alone.

Funding for older people's disability support services (65s and over) has been devolved to DHBs from 1 October 2003, subject to DHBs proving themselves capable. DHB capability is to be judged according to *The Health of Older People Strategy* (Dyson, 2002) which requires them to provide an integrated continuum of care. DHBs must also show that they have risk management plans to ensure DHB clients as a whole will not be adversely affected by the devolution, and that they will adopt a nation-wide approach for consistency of contracting residential care services for elderly people.

Funding for younger people's services will remain the responsibility of the Ministry of Health until at least 2004 when the Ministry will report to Cabinet on how funding should be managed. Younger people's funding is not being devolved with older people's funding because of a concern in the sector that DHBs, with their health focus, are not the appropriate place for disability funding.

Even though DSS funding has not been devolved, DHBs are required by statute to have a Disability Support Advisory Committee (DSAC). Even without funding, the Minister for Disability Issues sees these committees as having a role providing advice to their DHB on the health needs of their disabled population. This Minister and the Ministry of Health have both made efforts to educate DHB Chairs about the role of the DSAC. According to informants, in practice the DSACs around the country are operating quite differently in different DHBs, ranging from those who regard the DSAC as having a minimal role until funding is devolved, to those who saw their DSAC as having an advocacy role.

Some providers deliver services for both younger people and for those aged 65 and over. In this case, providers will need separate contracts, with the Ministry of Health and also with the DHB in their area, for the services they provide to younger people and for the services they provide to those 65 and over respectively. Furthermore, some providers deliver services that span several districts. Providers are also concerned about the potential for inconsistency across 21 DHBs. Further issues arise as people move from one age category into the other.

DHBs have concerns that they are taking on an under-funded service. Funding for older people is largely made up of residential care or rest homes. Residential care is demand-driven. With an ageing population, DHBs are concerned that demand will increase to an unmanageable level. The work of 'Ageing in Place', in conjunction with *The Health of Older People Strategy* (Dyson, 2002), means that people will be supported to stay at home longer which may alleviate some of the increase in demand for residential care.

There are also potential workforce problems for DHBs. The Disability Services Directorate in the Ministry of Health will devolve some staff with the devolution of funding. However, there are more DHBs than staff members to be devolved. One DHB informant points out that if the administrative funds are devolved with the disability support services funds, then the DHBs can recruit staff, but problems could arise if this does not occur.

6.6.5 Context: The Policy Expectations of the Primary Health Care Strategy

The Primary Health Care Strategy (PHCS) was introduced in February 2001 to create 'an overall framework for the organisation and delivery of primary health care' (King 2001a) and thus provide direction to DHBs regarding the provision of primary health care to their populations.

The PHCS is focused on reaching those not currently well served by primary care, extending primary care provision into population health, and changing modes of service provision through PHOs. Ministers' and officials' expectations are that health professionals will cooperate to deliver holistic health, which is affordable and accessible.

6.6.6 Findings: The Primary Health Care Strategy

Amongst those working within the sector, there is general agreement with the principles and aims of the PHCS, for example the potential for greater integration of services, teamwork and innovation. However many of those we interviewed expressed dissatisfaction with aspects of the consultation process undertaken during the development of the strategy and implementation plans. Although opportunities for consultation were offered, sector representatives expressed doubts about the willingness of the Ministry to accept the comments they had to make and to reflect these comments in implementation plans. Sector representatives had a sense of the Ministry being disconnected from the sector. Many sector representatives regarded the implementation policy guidelines as inadequate in detail.

Those in the sector expressed a desire for more explicit guidance in the transitional period and with regard to the setting up of PHOs. Major concerns were expressed about issues of equity during the transition period, and about insufficient funds being available in the longer term to fully realise the vision of low cost health care for all.

Sector representatives commented on the 'huge commitment of resources and energy' required for setting up a PHO, exacerbated and perpetuated by the demanding information and reporting requirements of the Ministry.

General practitioners have expressed fears about safeguarding facets of general practice, such as the right to charge patient fees (co-payments)⁸. There are also concerns about the potential for a more demanding workload due to a combination of greater concentrations of high needs patients and other professions taking over some of the more routine tasks. To mitigate the impacts it is expected there will be increased need for clinical supervision (between GPs and of other professions), mentoring of nurses and more on-going education for nurses.

Although health professionals normally work well together, the uncertainty about the new structures and funding arrangements has raised anxiety in professional organisations about the relative roles of various providers and health professionals. There is also a reappraisal of the value of existing services compared to new ones. Nurses and allied professionals have concerns about general practitioners dominating, both at the governance level and at the service level. Allied health professionals have concerns that the holistic health intention involving funding for health professionals other than GPs and nurses will not be implemented.

More than half the CEOs commented on the government's expectations in terms of the desired outcomes of the policy (health status improvement, reorientation of health services, more efficient use of resources) and overall they endorsed the merits of the policy. There were concerns among CEOs interviewed early on about the expectations of implementation ('the worst policy I've ever seen'; 'naive') and that this might prove to be more difficult than anticipated. Some CEOs interviewed more recently expressed concern over the high level of Ministry control over the implementation process, which they attributed largely to concern over political risk.

Some informants have expressed concerns that some independent practitioner associations (IPAs) will make superficial changes to their governance structures and transform into PHOs, but in doing so, may defeat the goals of the PHO concept.

⁸ This issue has now been resolved.

Amongst the case study DHBs, some DHBs have been very proactive in assisting with the development of PHOs in their districts and several have a number of PHOs established in their area. One DHB reports faster than anticipated progress.

Informants identified a number of strengths with the Strategy. Community involvement in the development of PHOs is considered a strength of the Strategy in one DHB. Some mainstream non-government organisation (NGO) providers are positive about the more social model for healthcare. Lower co-payments for Maori, Pacific and lower socio-economic patients, and increased flexibility with capitated funding were identified strengths.

A number of issues have been raised, including:

- The plan to have geographically-based PHOs in one DHB has not received support from some primary care providers, as providers contend that many consumers do not access primary care services according to their geographic location.
- Some DHB interviewees were critical of the slow progress of the Strategy and of inadequate funding. There were also comments from one DHB that more is needed in terms of the realities of implementation.
- PHO development is seen in one DHB to have exacerbated capacity issues for some Māori, Pacific and low-income providers, especially since they were the first groups to set up as PHOs and had none of the advantages of learning from the experience of others. Information technology capacity was noted as a particular concern.
- In one DHB, concerns were raised that there is potential for the PHO structure to create another level of bureaucracy, with their role and interaction with the DHB seen to be potentially problematic. In the same DHB there was seen to be a potential mismatch in funding decisions taken by the DHB and those by the Ministry for PHOs.

6.7 Funding

6.7.1 Context: Legislative Frameworks, Theoretical and Policy Expectations

The Crown funds the DHBs (s.10) in return for the providing, or arranging for the provision of, agreed and specified services. Under the Act, the DHBs are responsible to the Minister, according to the Public Finance Act 1989 (s. 37), and must operate in a financially responsible manner (s. 41). This is defined in terms of each DHB endeavouring to maintain its long term viability, to cover all its annual costs from net annual income, to act as a successful going concern, and to prudently manage its assets and liabilities.

Accountability to the Minister includes following the direction given by the national framework of strategies and priorities, plus being fiscally responsible. Some key informants were concerned that DHBs might not take the budget constraint seriously and may not make the changes they need to make in service delivery in order to remain within budget.

6.7.2 Findings: Funding

One key informant predicted that the hardest thing for DHBs will be to live within their budgets, because there will be on-going pressure on funding, and because of the competing pressures and complexities in spending decisions, e.g. balancing the needs of staff with those of patients. Another key informant suggested that the major challenge will be insufficient funding for DHBs to do the things they are being asked to do.

All CEOs acknowledged the expectation was to live within budget, and where necessary, to reduce their deficit within three years. Several CEOs noted that the three year funding pathway set out by government was helpful, but also drew attention to cost drivers in the system beyond the control of DHBs that need attention nationally, for example, the cost of blood products, pharmaceuticals, wage pressures arising from labour market issues and pressures arising from changes in the exchange rate.

In one case study DHB it was noted that balanced against strategic goals set by the DHB are the resource constraints within which the DHB must work. Increased collaboration with other DHBs and greater inter-region service collaboration are seen, for smaller DHBs, as ways of getting around resource and funding constraints and still delivering services. In another DHB a comment was made that where there are high expectations, “hump” or transition funding is needed.

The population-based funding formula is seen as a significant challenge in some DHBs. In one there is a perception that the formula needs to be robust with local conditions and local implications being considered; in another it is seen as potentially restricting patient choice as the funds no longer automatically follow the patients. In one DHB a concern was raised that the formula uses out-of-date population statistics resulting in under-funding for DHBs with rapid population growth and a rapidly changing ethnic mix⁹.

In one DHB it was noted that there is not enough money to meet government or public expectations. This means there is a need for fairly strong rationing decisions, which have to be politically driven.

⁹ Projections based on 1996 census data will be used for 2003/04 population-based funding formula; projections based on 2001 census data will be used for 2004/05 funding (personal communication, Ministry of Health).

6.8 Purchasing and Contracting

6.8.1 Context: Theoretical and Policy Expectations

The move in 1993 towards a purchaser-provider split in the NZ health system followed similar policy developments in other countries (Secretary of State for Health 1989; Ham and Brommels 1994; World Health Organisation 1996; Mays, Cumming, Fraser, Hand and Davies 1999). In relation to purchasing and contracting, the system was seen to impose high administration costs imposed by a fairly legalistic and at times acrimonious contracting system, exacerbated by providers having to deal with four RHAs in the first instance and short, one-year contracts (Rivers Buchan Associates 1995; Ashton 1996; Malcolm and Powell 1996; Cumming and Salmond 1998; Ministry of Health n.d., Newberry and Barnett, 2001). It was suggested that the 1993 reforms would lead to CHEs making significant efficiency gains (Upton 1991). Evidence suggests this did not occur (Ashby 1996; Contract Monitoring Group 1996; Deloitte Touche Tohmatsu 1996; McKendry, Howard and Carryer n.d.), although a number of explanations have been put forward for this, including that improved accountability through contracts may have made it harder for CHEs to reduce services (Deloitte Touche Tohmatsu 1996). Moreover, the competitive approach has been argued to reduce co-operation in the health sector, and in one case, to have lead to acrimonious relationships between managers and clinicians, as well as poor quality care where attention focused on financial rather than clinical performance (Health and Disability Commissioner 1998).

The 1993 reforms have been argued to bring some benefits: increasing numbers of GPs have moved onto contracts and are working together through groupings such as IPAs; greater use of capitation and budget payment systems in primary care with improved incentives for managing expenditure (Ministry of Health 1995; Contract Monitoring Group 1996; Kerr, Malcolm, Schousboe and Pimm 1996; Malcolm and Powell 1996; Malcolm 1997; Malcolm, Wright and Barnett 1999); greater clarity, focus and increased accountability for CHEs and voluntary providers (Rivers Buchan Associates 1995; Contract Monitoring Group 1996).

The reforms were also seen to bring an increased focus on trying to meet obligations under the Treaty of Waitangi. However, the delay in practical implementation followed by two major structural changes during implementation was detrimental for Māori: ‘These ‘changes’ had the effect of disestablishing Māori health initiatives, which found a lack of consistent policy and, in some cases personnel from one month to the next’ (Cunningham and Durie 1999). Other factors highlighted were the “mixed messages” around purchasing arrangements, the difficulty in responding to ongoing shifts in focus, the lack of security related to limited one year contacts, increased monitoring activity, and the need to fund increased transactional costs and the development of management infrastructure (Cunningham and Durie 1999). On the other hand, there is a perception that opportunities for Māori increased during the 1990s, as a result of some RHAs and the HFA developing co-purchasing strategies with Māori, contracting with CHEs and other providers for improvements in cultural appropriateness, promoting Māori programmes and facilitating the development of Māori providers (Contract Monitoring Group 1996; Ministry of Health 1997; National Advisory Committee on Health and Disability 2000).

Key issues for research in relation to DHBs therefore include examining which, if any, of the above benefits are retained, and whether problematic aspects of the competitive model are removed. An issue of particular concern is whether the re-integration of purchasing and provision in DHBs will lead to greater or lesser opportunities for community providers (Ministry of Health 2000).

Similar issues were raised in key informant interviews. One key informant anticipated that problems would arise because decisions on what services to buy or provide are being taken by an organisation that provides some of those services. Another expressed concern that hospitals would dominate again under the model, as they felt had happened previously with AHBs. This key informant was concerned that there would be a lack of will to shift resources to the population focus.

The same key informant also pointed to the excellent ‘community development’ that took place under the ‘quasi-market’ model of the RHAs and HFA where small organizations grew in capability and confidence. This had included the involvement of Māori organisations in planning, decision-making, monitoring and evaluation, although others had seen these developments as undermining the integrity of the publicly-owned health system.

According to some key informants, some contracts held nationally by the Ministry were not (and may not be) devolved because it would mean, for example, fragmenting a very small contract between 21 DHBs. According to a number of those we interviewed, this decision was driven partly by government policy makers’ and advisors’ concerns about transaction costs likely to be involved in devolving contracts, but also due to ‘pressure’ from providers concerned about the same issue. Contracting with, and reporting back to, 21 DHBs was seen to be costly and complicated.

6.8.2 Findings: Purchasing and Contracting

In the Board member survey, Board members expressed mixed views as to whether the Board is able to monitor service quality through provider contracts.

Case study informants gave mixed accounts of the devolution of contracts. Some DHBs reported that most contracts were devolved 1st July, 2001, six months after the establishment of the DHB, though at least two of the DHBs had an extended period of time during which contracts were handed over in a step-wise manner. For the DHBs with delayed devolution, there were complaints that they could not prepare for managing the contracts and there were long delays in getting access to copies of the contracts. At least one case study has found the process of hand-over to be excessively slow, which meant the DHB did not have copies of contracts even when they were responsible for managing provider organisations.

Two case study DHBs reported problems due to contracts being incomplete. For example, they noted inaccurate funding figures, other inaccuracies, and missing details. One case study DHB noted that the mental health contracts were generally tidier, compared to the personal health contracts. All of the case study DHBs identified the due diligence process of checking the contracts as their first priority. This meant checking the transfer: were all the contracts passed over, were the individual contracts complete with all variations and associated letters, and did the money devolved match the contract obligations.

All the case study DHBs spoke of initially rolling over the majority of contracts. This was because of the large numbers of contracts received within a short time and DHBs feeling they had a first priority to check contracts for completeness; that they needed to take stock of what was working; and because the contract terms determined when review was possible. One case study DHB informant placed priority on minimising risks to the organisation. This informant stated they put monitoring processes in place but then avoided making changes which may have disrupted the sector, while they allowed time to observe what worked.

Some case study informants noted that the DHBs did not initially have the capacity or capability to manage contracts. In the previous model, contracting had been done by the HFA. Comments suggest DHB funder arms had to rapidly upskill to manage this new role: some staff still consider contracting difficult to manage. One key informant spoke of receiving the contracts when they were still in the process of appointing contract managers, so they relied heavily on the shared service agency to manage the contracts on their behalf. Another noted the DHB received contracts when they were still developing their strategic plans, which would have placed limits on their ability to review the contracts if they had attempted it at that stage.

Once contracts came up for renewal, some were rolled over whereas some were renegotiated. One DHB indicated its priority was deficit management, so that the primary concern was looking for contracts that could be terminated. However this same DHB also attempted a ranking exercise with a number of contracts being ranked according to a set of principles, including impact on health outcomes.

Other case study DHB informants also spoke of considering the contracts against their overall strategy. How quickly an individual contract was reviewed depended on the magnitude and importance of the contract, the significance of the provider, and the likelihood of political repercussions.

DHBs and providers in several case study districts reported major problems with the devolution of contracts. For one DHB, there were reported long delays in getting access to copies of the contracts in the early days. Another noted some contracts were unfinished and out-of-date, with discrepancies. This latter DHB noted there was learning on both sides with the DHB becoming more assertive in subsequent waves of devolution in terms of what was acceptable. However, delays meant that DHBs could not prepare for managing the contracts.

As noted above, some DHBs just rolled over contracts with providers, making few changes while they concentrated on other aspects of establishing the DHB. Renegotiation of these contracts with providers is just beginning to occur. Contracting is also a new responsibility that former HHS staff did not have to manage under the previous HFA model. Comments suggest DHB funder arms had to rapidly upskill to manage this new role. Some staff still consider the contracting role to be difficult to manage.

Provider Issues and Perspectives

For providers, it has been noted in one DHB that disagreements between the DHBs as to who pays for some patients crossing DHB boundaries has resulted in delays in payments for providers.

In one DHB, the comment was made that accountability requirements set by some DHBs are seen as onerous by small providers. Some providers in another DHB are frustrated that contracts are not focusing adequately on outcomes and sometimes even require the purchase of specific inputs (eg a particular position such as a coordinator).

In one DHB it was noted that the dual roles DHBs have as providers and funders can create tensions for non-DHB providers. Thus, for example, if something happens with one of those relationships, there is potential to ‘diminish’ the other. In addition, this is especially a problem where services are provided – or can potentially be provided - by both a DHB and by non-DHB providers (such as long-term care for the elderly and maternity services). Some providers expressed concern that in such circumstances DHBs would give preference to the DHB provider arm.

Some regional and national providers have to deal with multiple DHBs regarding contracts. In one DHB, there was a perception that national planning under the HFA was easier; and it was suggested that obtaining consistency and cohesiveness of contracting across DHBs is potentially problematic. Staggered devolution has also created difficulties for some NGOs/providers that provide services across devolved and non-devolved funded areas as they have to manage both central and local contracts.

In one DHB, it was commented by NGOs that generally the smaller DHBs are more proactive in forming relationships with NGOs. Some informants have commented that organisations are still in competition with each other to some degree, for example in relation to nursing and Māori staff.

Some NGO stakeholder informants observed DHBs as not understanding the NGO sector, and under-utilising the expertise they offer. However there is variability between DHBs; some are seen as becoming more dynamic and innovative with flexible approaches, while others are still locked into previous more rigid contracting. The NGO stakeholder informants tended to associate innovation more with the smaller DHBs.

6.9 Treaty of Waitangi and Māori Health

6.9.1 Part 1 – Introduction

Part 1 reports on the key informant interviews. This section summarises the views and insights of respondents, based on a preliminary analysis of key informant interview data. Thirty-six key informants were interviewed between December 2001 and July 2002. They were ministers, members of Parliament, government officials and national commentators on Māori health from academic institutions.

Sixteen Māori and two non-Māori were interviewed regarding the development of the *He Korowai Oranga/The Māori Health Strategy*, primary health care, the Treaty of Waitangi and the perceived strengths and weaknesses for Māori of the 2001 reforms. A further 17 non-Māori were interviewed regarding the Treaty of Waitangi, the drafting of the NZPHD Bill and the debates around the *manawhenua* clause which was later removed from the Bill.

Some key informants were chosen on the basis of their involvement and contribution to the inclusion of the Treaty of Waitangi clause in legislation, and others for their knowledge of the development of *He Korowai Oranga/The Māori Health Strategy*. Their expectations of these major changes in the health system and possible impact on Māori providers and Māori health status were also explored. Purposeful and snowball sampling methods were used.

The questions used in the interview schedule were derived from the overall objectives of the evaluation project. Data were coded thematically using Nvivo and the analysis was carried out by members of the Māori team.

As noted earlier, we are reporting here in particular on the issues and themes identified by those people we have interviewed. These findings are also based on preliminary analyses only. Further, as qualitative research, and given some interviews were undertaken in order to elicit issues for follow-up in other streams and phases of the research, the issues noted here reflect the views of some in the sector. In particular, key issues are noted where views were very strongly expressed. It is not appropriate to reflect from our report that the issues raised are generalised throughout the sector. Later streams and phases of the research will follow-up on issues raised here and will be triangulated across data sources and sites in order to infer both the range of views and the generalisability of those views.

The Treaty of Waitangi

The inclusion of a Treaty of Waitangi clause in the NZPHD Act was seen as a significant step in compelling DHBs and the Ministry to incorporate the Treaty in their business. However frustration was expressed over the changes to the Treaty statement in its transition from a Bill to an Act. Key informants perceived the Treaty statement in the Act (s.4) to be a less effective, “diluted” statement from the original statement in the Bill. The Bill initially included a clause ‘consistent with the principles of the Treaty’, which applied to the whole Act, and therefore to all the agents and organisations referred to in the Act, including DHBs, Pharmac and the National Health Committee. The Act when it was passed confined the Treaty clause to Section 4 which only applies to DHBs. There has been on-going debate about the significance and the implications of the Treaty, as enacted, at a national and local level.

Key informants were asked to define the Ministry's and DHBs' Treaty obligations. This was a topic of interest to many key informants and there was a diversity of views expressed. Some felt that by shifting the Treaty relationship from the Minister/Ministry to a crown agency, the DHB, there was an abdication of *kawanatanga* responsibilities and that was not consistent with the intent of the Treaty.

Other informants thought that the Treaty clause in the NZPHDA operationalised the Treaty as it required the Crown to address Māori health issues in the present, rather than the Crown's traditional role of dealing with historical Treaty issues. This is a positive step, giving it a 'modern, legal presence' in the health system. It was also thought honouring Treaty commitments means the health system will have to take the involvement and management by Māori more seriously.

Informants also thought the purpose of the Treaty clause was to provide DHBs with a platform upon which to build relationships with Māori. The Act establishes a new Treaty relationship between the funder (DHB) and Māori. Informants hoped it would shift the focus from increasing the number of Māori health providers to improving health outcomes for Māori. One informant said that though nothing in the law makes things change, it helps to focus attention on Māori health.

Strengths of the 2001 Reforms Model

Key informants reported Māori participation as a strength of the reforms. They indicated that this participation included involvement in service delivery, policy development and the prioritisation process for the allocation of resources to Māori health. This involvement was supported by the legal requirement for Māori to participate at a governance level. That is, the Act stated the Minister must endeavour to ensure Māori membership of the DHB is proportional to the number of Māori in the DHBs' resident population and in any event must ensure there are at least two Māori Board members on each DHB governing Board. This, and the clearly signalled commitment from the

Minister of Health and Associate Minister of Health (Māori) to improving Māori health, was identified as guides to DHBs to better position their services to Māori.

There are explicit goals for Māori which appropriately separate them from other population groups, through the Act, the New Zealand Health Strategy and *He Korowai Oranga/The Māori Health Strategy*. This was identified as a positive development by informants. The ability to benchmark DHB performance into the future by examining expenditure on Māori is also seen as positive. However this is dependent on the accurate collection of ethnicity data. One informant stressed that many variables that impact on health lie outside of the health sector, e.g. housing, education and that improvements to Māori health cannot be reliant on a single intervention.

The model reflects a more holistic approach to health which is more in line with the Māori world-view.

The intention of the current reforms, as expressed in *He Korowai Oranga/The Māori Health Strategy* was to build on the gains made in Māori provider development under the RHA and HFA models. This model provides an avenue for Māori who want to work with DHBs.

The increased focus on, and funding for, primary care was also seen as positive, based on the assumption that better access to primary care will improve health outcomes for Māori.

Some informants suggested that the support from central government through legislation and strategies on issues such as Māori participation in the health and primary care sectors were strengths of the reforms:

‘...well I mean the current reforms are pretty much in line with what Māori have been saying for a long time, we want to actively participate in Health, don’t want to be just consumers, we want to be delivering services, want to be helping with policies, want to be in the prioritisation process’.

Weaknesses of the 2001 Reforms Model

One informant discussed the effects of the model being essentially a local body model, and commented that Māori have a long history and confidence in dealing with Central government. Local body experience of working with Māori and the Treaty of Waitangi is very recent. Māori feel they have not always fared well at the hands of local bodies.

Three informants reported that DHBs are preoccupied with addressing deficits, and concern was expressed that attention is still weighted towards the hospital sector.

Concern was also expressed that the 21 DHB structure requires at least 21 Māori partners but some districts may have difficulty in putting forward people with the appropriate knowledge and skills to fulfil the partnership relationship.

Disappointment was expressed by one informant that the Māori Health Strategy was not a higher priority in the list of strategies, and that it was not legislated. Naming the Māori Health Strategy in the New Zealand Health Strategy did not go far enough.

One informant expressed concern about the inherent bias toward the dominant culture, at the expense of Māori health within the system. This was illustrated by the poor Māori health statistics eg, lower life expectancy, premature deaths and greater burden of disease, which were seen as demonstrating institutional racism. Some informants expressed cynicism over the capability of the system to deliver health improvements to Māori, given a long history of inadequate health care delivered by mainstream providers, and the level of inequalities experienced by Māori. It was also stated that Māori health along with the NGO sector is in the “weak” part of the health sector and is considered to be “poor”. As Māori provider organisations are in the primary, public and community health sectors, they have been less resourced than the hospital sector. It was thought that without more resources there could be a contraction of service, and more importantly a contraction of the initiative and innovation which have driven Māori health development.

Another informant said it is difficult to say whether participation at governance level alone will translate into health gains, given that some of the variables that impact on health lie outside the health sector eg. poor housing, education, unemployment.

It is unclear how much discretionary funding DHBs will have. The informant who raised this issue felt it likely that direction for spending would come from the Ministry and not be at the discretion of the DHBs.

One key informant stressed the necessity to quantify mainstream provision to Māori, to enable the measurement of progress indicators. On the other hand it was felt Māori providers have been heavily scrutinized.

Manawhenua and Tangata Whenua Relationships

During the transition from Bill to Act there was considerable debate around the *manawhenua* and *tangata whenua* relationships. This issue also attracted a lot of public interest while the Bill was debated in Parliament. The issues raised by informants were around the following points:

- Disappointment was expressed at the significant changes between the Bill and the Act which reduced the focus on the rights of *manawhenua*. The changes were considered to be about the debate between an urban Māori and traditional *iwi* base. One informant felt it was done because it was necessary to give consideration to the large urban concentration where *iwi* are not so predominant.
- Legislating the *manawhenua* clause was interpreted by some politicians as creating different classes of Māori, which was unacceptable. However another politician stated that at the governance level the relationship is with *manawhenua*, but at a provider level it is with *tangata whenua*, all Māori.

He Korowai Oranga/The Māori Health Strategy

Some dissatisfaction was expressed with the processes for developing *He Korowai Oranga/The Māori Health Strategy*. At the operational level the process was seen to be under-resourced. Further, key participants appeared to be selected on the basis of their involvement with the New Zealand health and disability sectors. Because of this, the opportunity to capture a wider range of Māori was seen by some to have been missed. As a result the framework for this Strategy was considered to have been drafted by a narrow range of people.

Others commented that the process of development was dogged by difficulties and tensions. This was attributed to a number of factors:

- Lack of time, direction and support within the Ministry; the need for a framework; erratic attendance at key meetings which led to inequities in information flow.
- Changing and uneven commitment from Cabinet Ministers to the principles of the Treaty of Waitangi; the necessity to debate the inclusion of the term ‘partnership’ in the Strategy; prolonged periods of uncertainty and disappointment that the Strategy would not be legislated.

Some representatives of the Sector Reference Group felt they lacked information, were not involved in decision-making and did not play a significant role. Consultation with the Māori health sector was considered important but calls from the sector for action and a stronger commitment to the Treaty of Waitangi were not heeded. In addition the voice of consumers was considered to be largely missing. This could be attributed to the lack of clarity around who the ‘real’ audience of the Strategy was, for example, DHBs, Māori providers, or Māori consumers.

More positively, it is thought the Strategy has built on the past gains but is also designed to move forward and is expected to be a useful tool for DHBs to reach the communities with poor access to health care resources.

Perceived Strengths of He Korowai Oranga/The Māori Health Strategy

The Strategy is seen as a formalisation of a specific health strategy for Māori with clear directions and pathways. The shift away from a deficit model and re-orientation towards *whānau*, the importance of child development, building conditions for good health and relationships with the community are thought to be positive.

The Treaty of Waitangi underpinning opportunities for Māori ownership, inter-sectoral involvement and partnerships between the Crown, the sector and Māori were identified as strengths by informants.

One informant described the Strategy as a sound foundation and sustainable plan which would go on, irrespective of Government changes. The link into the NZHS and NZDS was also noted positively.

Others identified the Strategy as an opportunity to change the direction of Māori health and encourage positive participation by *whānau*, *hapu*, *iwi* and Māori communities.

Perceived Weaknesses of He Korowai Oranga/The Māori Health Strategy

It was noted in interviews that some *iwi*, *hapu*, *whānau* and communities will need more help than others to achieve the commitment required to the Strategy. Key informants also commented that the meaning of *whānau ora* and its measurement is unclear. This is problematic in that the Strategy identifies this as central. If it is unclear what this is, how will providers and DHBs know when this has been achieved?

Some viewed the Strategy and the environment in which it will be implemented as a top-down approach. DHBs will have control, and success will depend upon their capability and expertise. Success depends on DHBs making the Strategy their core business but there are concerns that some DHBs may not make it a priority.

One key informant therefore felt inadequate funding was a risk to successful implementation of the Strategy. The Strategy has been released into a deficit environment and it is unclear whether new money will be available to implement it. Ministry support and commitment is unclear and implementation and monitoring processes have not been well defined.

Informants noted that the Strategy was built on gains made in the past eight to ten years and was a move forward. However there were concerns that the Strategy would be ineffective unless there is political will to improve Māori health. Without political support there will always be challenges for Māori health advancement and development.

Whakatātaka/The Māori Health Action Plan

One informant thought government officials were cautious about releasing a Māori Health Strategy and Action Plan so close to the election. Opinions were mixed about whether there should be one or two documents released and whether they should be strategic or operational. Much comment was made regarding the political nature of the (subsequent) Action Plan and its timing. It was thought the release of the Action Plan was delayed by Cabinet; that it was considered too risky to release before the election because it “might threaten white complacency” and have negative polling results for the government.

Whānau Ora – Definition

As *whānau ora* is the cornerstone of *He Korowai Oranga/The Māori Health Strategy*, it was therefore appropriate to ask participants what they thought *whānau ora* was. There were diverse responses to this question. In the following quote one respondent succinctly raises an issue that many other respondents had also pondered:

‘Well there are two broad ways of looking at *whānau ora*. Are we talking about the members of the *whānau* or are we talking about the *whānau* as an entity a collective...If you look at any of the publications of *whānau ora* including the ones from the Ministry, they are immediately unbundled into health of children, the health of *rangatahi*, the health of old people, the health of women, men and so it very quickly shifts to the health of people who make up the *whānau* rather than the health of the *whānau* [as a collective]’.

Some thought this emphasis could mean that everyone must belong to a group and that individuality may be lost. Another common response was that *whānau ora* was about helping Māori families to achieve their maximum health and wellbeing.

It was also noted that *whānau ora* is not just about health. It has implications for other sectors, but informants observed silos still exist within government therefore making it difficult to view *whānau* in its broadest context. The consensus was that there needed to be education within the health sector about what *whānau* is.

Whānau Ora – Implementation

Informants identified what they consider necessary for the successful implementation of *whānau ora*:

- An urgent need for an action plan and tool kits which reflect *iwi* aspirations and for an inter-sectoral monitoring and implementation agency.
- The need for multiple inter-sectoral data collection processes across a range of socio-cultural, psychological, individual and collective indicators including Māori workforce development and cultural identity.
- The need for good leadership models, Māori involvement in decision-making and clarification of funding issues.

Whānau ora – Measurement

‘If you are measuring the health of a *whānau*, I think you need different indicators, there you would need to measure things like is this *whānau* able to care for its people. If it can’t care for its old and its young then its not a healthy *whānau*’.

Participants were also asked how they would measure *whānau ora* or know when progress had been made towards achieving *whānau ora*. Again there was discussion around whether it was more appropriate to measure the health of individual *whānau* members or the health of *whānau* as a collective. However participants commented that when developing indicators of good health, cultural identity must be taken into account, and not just the absence of disease.

Measuring health outcomes was seen as an appropriate measure along with Māori workforce development, and funding allocations were also mentioned as areas that could be measured.

Primary Health Organisations

Informants expressed anxiety about the impact PHOs would have on Māori health providers. Many of them forecast that Māori would be at risk of being coerced into relationships with mainstream providers who do not share their strategic orientation and openness to working in a multi-disciplinary manner. Concern was also expressed that funders would fail to recognise the strategic strengths of Māori providers in that many Māori providers already have a mix of services within their organisation.

One informant observed that the language used by Māori provider participants around the formation of alliances with mainstream providers, particularly IPAs, included terms like ‘temptation’ and ‘seduction’. Māori may be forced into these relationships because of the pressures of economies of scale (Māori providers tend to be small) and risk losing their identity.

Informants noted the importance of having Māori providers in PHOs. Many Māori providers already meet the key components of the minimum requirements of *The Primary Health Care Strategy* such as a, ‘mix of service providers, not just doctors...community owned ... communities play a major role in the organisations...more holistic’.

Several felt the small size of many of the Māori primary care providers put them at risk in the PHO environment.

Questions were raised about enrolment rules and service specifications and how casual patients and highly mobile Māori patients will be funded. Māori tend to use more than one GP, so enrolment, mobility, and casual use of services are particularly pertinent.

Māori Providers

Although *He Korowai Oranga/The Māori Health Strategy* tried to build on the gains made over the past eight to ten years, informants were still anxious about the impact these reforms will have on Māori.

Informants were concerned that DHBs may stifle the creativity and innovation of providers. Financial implications were raised as an issue since many Māori providers are small and consequently have high transaction costs compared to other larger providers. There are also tensions between improving health, running a business and improving professional standing (for example through training and accreditation).

Of particular concern are workforce difficulties. Māori providers find it difficult to retain qualified staff, as competition is high. The fragility of the workforce is heightened by the greater burden of ill-health among Māori patients, therefore putting staff under pressure.

What Should Be Evaluated?

Informants identified what they considered to be the key actions and indicators necessary to progress and assess the effect of the reforms on Māori health. These include:

- Measurement and improvement of health outcomes.
- Measurement of how much money is spent on Māori, not just Māori specific services.
- Transparency in decision making on Māori expenditure.
- Development of policies for recruitment and retention of a Māori workforce.
- Assessment of how mainstream providers deliver to Māori.
- Making Māori health and decision-making about it a priority.

6.9.2 Part 2

Part 2 contains data from the five case study sites. These findings are preliminary only. A full analysis of the data has yet to be carried out. Interviews were conducted between August 2002 and June 2003. We interviewed DHB Board members, senior DHB staff, and community providers.

Relationships with Māori

Questions about DHB relationships with Māori drew mixed comments. In some DHBs the current environment is receptive to Māori influence being asserted. Some DHBs have established Māori governance group arrangements to provide advice on strategic policy, and direction. The arrangements differ from area to area. In one district, the governance group has a partnership arrangement with the DHB Board, in another it sits outside the DHB. In two districts, *manawhenua* have invited representatives from *taurahere* to participate in governance. In another district, there is a formal relationship with *manawhenua* and *mātāwaka*. In four districts the *manawhenua* tend to include other Māori living in the district. In one district the Chair and CEO meet on a monthly basis with a Māori governance group. Overall it was thought Māori governance groups are not well resourced.

In one case study district, a senior DHB manager suggested the need for a mechanism where Māori providers can interact with the Māori governance group. They also thought there is a need for direct *whānau* input into how best to shape services and that more work with *whānau*, *hapu* and *iwi* is required.

There is evidence of DHBs developing protocols for communication and working together with Māori, and that relationships are evolving. In some districts, there are supportive *kaumātua* and Māori Board members. Some Māori feel establishing and maintaining relationships with the DHB is ‘hard work’. Some Māori feel they experience racism, for example where Māori are put down by others in the organisation.

Issues for DHBs

Informants identified a number of issues that DHBs need to take more seriously: making Māori health a priority area, quantifying the amount spent on Māori health, and gathering ethnicity data. It was felt by a member of a Māori governance group that Māori health is still defined and delivered ‘from a Pākehā perspective in a Pākehā world’. Māori providers are also expected to work in this way.

The Chair of one of the DHBs noted that the election process disadvantages Māori because the ward system means that only a few Māori reside in each ward.

Another senior DHB manager suggested that there would always be a tension for Māori within the DHB in terms of their accountability to *iwi*, given that Board members are accountable to the Minister of Health and staff are accountable to the DHBs.

Treaty of Waitangi

The expectations of the Treaty relationship as expressed by case study informants are that Māori and non-Māori health status should be brought up to the same level, that resource allocation is fair and Māori have the right to determine their own system of health care delivery.

Some managers thought that it is easier to work with Māori now that a requirement for recognising and respecting the principles of the Treaty of Waitangi and for improving health outcomes for Māori has been legislated. It was expressed as “Pākehā having an obligation and Māori a responsibility” for the Treaty. However, there are still some on DHB Boards who do not support the Treaty and this is uncomfortable for Māori. One key informant said there must be action, not just lip service about honouring the Treaty. It was also suggested that Treaty obligations should be a minimum requirement of PHOs¹⁰.

Ministry of Health

There was dissatisfaction expressed by some senior DHB managers with the Ministry of Health: two labelled the Ministry as “invisible” and others indicated that input from the Ministry at the DHB level would be welcomed. Better communication was one of the issues identified, but other than this, these informants did not explain what sort of input they would like. This will be explored in the ongoing research.

There was also a complaint made by providers that they have sent monitoring reports to funders, including the Ministry of Health, for years but have received little feedback. The type of response expected from providers will be explored in our on-going research.

Allocation of Capital Expenditure

In our interviews we asked about whether DHBs had considered allocating capital expenditure to Māori providers to assist with any expansion plans they may have. This was considered to be a national issue but DHBs claimed they were not encouraged to invest in other providers. For one DHB, capital funding is tied up with legal, safety and compliance issues and a new regional hospital. In another district, there was no capital expenditure for non-DHB providers as such.

¹⁰ The process of establishing a PHO is to reflect the principles of the Treaty of Waitangi – partnership, participation and protection (King, 2001b).

For Māori providers, this lack of capital allocation was a ‘big problem’, particularly where demand for services is growing beyond the space available. Occasionally there is funding for equipment but not for facilities.

Māori Workforce Development

DHBs, like others in the sector, are aware of the need to plan for Māori workforce development. Some considered that they have been caught out through lack of vision and planning in the past. The number of Māori staff in terms of full-time equivalents in DHBs is still quite small.

Funding and Planning

A senior DHB manager stressed the necessity for Māori funding and planning managers to have an overview of primary, secondary and tertiary services. At present the money spent on primary care for Māori is seen as insignificant.

At present planning is undertaken by DHB and non-DHB providers rather than *whānau* and *hapu* – some would like to see this change so *whānau* and *hapu* make a greater contribution.

Provider Audit

In one district, dissatisfaction was expressed at the way in which recent audits had been conducted. Issues raised were: audit teams came with DHB best practice ideas which did not necessarily suit communities; reports were sent directly to the DHB, and the providers were not given an opportunity to respond to comments. In one case there was also a perception that the audit team came to ‘dig dirt’. Generally there was a feeling ‘that we are being audited all the time’.

Whānau Ora

The notion of *whānau ora* was considered by senior DHB managers to be a strengths-based approach but also a difficult concept to operationalise. A number of those we interviewed discussed *whānau ora* in two main categories. The first related to a strong cultural identity. These cultural concepts included the knowledge and practice of *whakapapa*, *whenua*, *marae*, *maunga*, *awa*, *manaaki*, *tiaki*, *awhi* and *tautoko*. The *whānau* also needed dignity to stand in today's world and to participate in anything that perpetuates *mana motuhake*, *mauri* and *mauriora*. *Mauriora* is considered to reside within *whānau*, and *whānau* need to be more self reliant and interdependent as well as having functions that strengthen *whānau* and *hapu*.

The second category related to service delivery. In relation to the way services are delivered, there was a need to revisit the Pākehā approach to services, focused on delivering care to the individual. One senior manager suggested that DHBs could contract in a way that will develop a *whānau*-led model and to start seeing *whānau* as a norm in discharge plans. It was suggested that piloting *whānau* models and different contracts would be a way to begin and that DHBs should resource *whānau* to start defining their own health needs.

The NZPHDA Model

Comments on the model overall were mixed. On a positive note, Māori providers saw the current reforms as a sincere attempt to do things better, and less competitive than previous models. Increased community involvement and better contact between providers and DHBs were highlighted as benefits.

However, there were also a number of concerns raised by the model. They are: the reforms have split Māori territorial boundaries, resulting in arguments between Māori when a Māori Development Organisation is holding a contract for a whole region; Māori have little decision-making authority, and Māori providers are still under- resourced.

Although some providers felt positive about the new model, a number of negative comments also emerged. Not all agreed the model was better than the HFA model, nor did they agree that there was a real commitment to improving Māori health on the part of DHBs. One senior DHB manager commented that change for Māori would require a different approach – a larger financial investment, more skills, a project management approach, plus real commitment.

Concerns were expressed at the establishment of a DHB-based Māori provider arm in one DHB. It left existing Māori provider organisations feeling increasingly vulnerable. It was also felt there is often a preoccupation with the hospital arm which could result in Māori issues getting dropped off the agenda.

Other issues raised by Māori providers included:

- Funding of contracts has remained static even though demand has grown.
- DHB contracts are too detailed and prescriptive.
- There are barriers to information by Māori, for Māori.
- DHB processes are a little slow.

Two informants considered the DHB model to be the least preferred model for one particular *iwi*, because they had been in the middle of negotiating other arrangements with the Crown, including budget holding, which was abandoned with the change of government in 1999.

Suggested improvements include a united Māori voice (all Māori across the DHB) rather than the “silo” approach of different groups all having a separate voice and formal processes to assist and monitor Māori provider organisation development.

One comment in relation to the model for Māori providers was that while DHB staff may come and go the one constant thing are their ‘people’ (Māori/*iwi*).

Primary Health Organisations

There was guarded support for the PHO model among Māori in the case study districts, and some Māori providers in two districts expressed appreciation for the level of support they had received from DHB staff. Assistance came in the form of information technology support in getting their databases ready for the new environment. Support was also expressed for DHB staff members working with Māori providers in two districts. However, it was thought by Māori providers that the concept of PHOs was driven by the government rather than by communities and some DHB managers noted that there are risks for small providers (as noted earlier, Māori providers tend to be small) and they need to be protected. A senior DHB manager expressed concern that the investment in PHOs is not big enough for the best outcomes.

In one district, a senior DHB manager commented about the lack of information available about setting up PHOs and felt that not enough attention was paid to recognising and addressing the historical control and power-base of clinical and medical interests.

It was felt that Māori providers becoming involved with PHOs would need independent support to help them protect what is uniquely Māori and to assist in operationalising their plans.

There is concern from one senior DHB manager that PHOs will become the sole focus of primary care, and that other areas of health could be overlooked.

6.10 Pacific Peoples and Pacific Health

6.10.1 Introduction

Of the 21 DHBs, seven have relatively high numbers of Pacific peoples within their population. These DHBs will have particular responsibility to plan and fund Pacific health services. These are Capital and Coast, Hutt, Canterbury, Waikato, Counties Manukau, Auckland and Waitemata. Of the seven, three are case study DHBs.

Chairs, CEOs, Pacific Board members, DHB Pacific personnel and Pacific providers were interviewed including six background interviews with key people to determine the planning and the development of the Pacific Disability Action Plan. The interviews took place between July 2002 and December 2002. The case study participants were interviewed in relation to the strengths and weaknesses of the health reforms; the planning, development and implementation of *The Pacific Health and Disability Action Plan* (the Action Plan); and governance and working relationships with Pacific providers.

The report is based on interim findings only. The key points selected are issues that respondents felt were central to the implementation of the vision, principles and priorities of the Action Plan. The issues raised in this report must not be seen as being of higher importance than the issues likely to arise from the data that has not yet been analysed.

Further evaluation of the implementation and progress of *The Pacific Health and Disability Action Plan*, DHBs Strategic Plans and Annual Action Plans, against the data from all the respondents will be included in the final report.

6.10.2 Findings: Pacific Peoples and Pacific Health

It is noted from the interviews that the seven priority DHBs with significant Pacific populations named in the Action Plan, have increased the number of Pacific people working at all levels in DHBs and involved in advisory committees. This means that there is a greater Pacific presence within the seven DHBs and more opportunity for Pacific needs to be addressed.

The focus of the DHBs on local health issues is seen as being positive for Pacific health. Informants indicated Pacific providers have higher expectations of the DHBs because they perceive there is more chance of Pacific health needs being addressed.

DHB Elected Pacific Board Members

There was a general feeling that the electoral process did not work for Pacific communities. The elections resulted in no Pacific representative being elected onto the Boards. All Pacific Board members were appointed and it was felt the appointment procedure should continue if people are not elected. At present there are four Pacific Board members, with Ministry identifying a fifth Board member. However, that Board member, although Pacific by descent, does not perceive their role as being a Pacific representative, as they were not appointed as a Pacific member.

The three Pacific Board members interviewed felt they were lone voices and found it difficult to get Pacific issues presented. The struggle is intensified by the fact that they are the only Pacific Board members for each of the three respective DHBs. However, having a Pacific representative at Board/governance level is important for the Pacific DHB personnel and providers.

Although there is an increase in the number of Pacific people working at all levels in the DHBs, most respondents felt there is a need for more Pacific representatives at governance and management level in all seven priority DHBs to drive Pacific issues forward.

Consultation with Community/Providers

Case study DHBs have different ways of consulting with Pacific communities and providers. For example in one case study DHB there is a Pacific Relationships Consultant who networks with providers and in another, the Pacific Manager works alongside providers by being regularly in contact and available to them.

When consulting with Pacific communities, DHBs need to take into consideration that conferring with one provider does not equate to the Pacific community as a whole. One case study informant stated that they had consulted with the Pacific community, but a provider pointed out that consultation often involved just one provider. DHBs need to consult widely.

The Pacific Health and Disability Action Plan

The Pacific Health and Disability Action Plan (the Action Plan) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples.

The vision, principles and priorities of the Action Plan will form the basis of future Pacific health and disability support policy and services. The Action Plan does not come with funding to implement it. Pacific providers hoped that there would be some Pacific tagged funding attached to it.

The Action Plan is used as a reference document when planning strategies for Pacific health. Some of the seven priority DHBs have used the Plan to develop specific Pacific Health Action plans and Pacific Health Strategy plans. It is also used as a reference in all of the seven priority DHB generic annual and strategic plans.

There were a few concerns about what are considered priorities, for example, the well being of elders is considered a priority by the community but is not in the plan. However, elders are being planned for in the Disability Strategy.

Key informants perceived the formation of the Pacific Reference Group as a crucial platform in the development of the Action Plan. One key informant commented that Pacific Action Plan captured the voices of Pacific people who had been talking about these issues for the past 10 years. The Pacific Reference Group guided the collection of the data and the priority areas that appear in the Action Plan.

Workforce Development

Most respondents felt that *The Pacific Health and Disability Action Plan* was based on health status information and needs of the population but the size and skills of the Pacific health workforce does not reflect the needs of the Pacific population.

The DHB personnel and providers see there is a real need to upskill and train the Pacific health workforce and provide appropriate career pathways.

Primary Health Organisations

The first Pacific PHO, Ta Pasifika, has been set up in South Auckland with a group of Pacific providers from across the three DHBs. This seems to indicate that Pacific providers recognise there is more opportunity for a significant Pacific presence by joining together than by being a lone presence within a PHO in each DHB.

One of the key informants was hopeful that being part of the PHO will allow Pacific providers to plan more strategically with communities and to use the community development model. It was hoped they would have access to more flexibility around resources rather than being tied to very short-term contracts.

Relationships Between DHBs and Pacific Providers

Some DHBs have well-established relationships with Pacific providers through their managers. Planning and funding relationships with Pacific providers are well established, but are dependent on the continuing flow of information and communication.

Sometimes there is a difference between how DHB personnel reported their relationship with Pacific providers and the community, and how the Pacific providers perceived their relationship with the DHB. For example, one DHB thought they had a close working relationship with Pacific communities whereas the providers reported that they were not adequately consulted.

Sometimes DHBs have worked together with a positive outcome for Pacific. For example, two neighbouring DHBs joined together to fund and support a fono of Pacific providers across the two DHBs. This was significant because it was the first time all the Pacific providers had come together and it allowed them to hear about one another's services and to meet staff from both DHBs.

6.11 Devolution

‘Devolution is the creation or strengthening of sub-national levels of government which are substantially independent of the national level for some defined set of functions’ (Mills, 1990).

6.11.1 Context: Legislative Framework, Theory and Policy Expectations Relating to Devolution

Under s. 23 of the Act, each DHB is charged with ensuring the provision of services for its resident population. The DHB is to develop co-operative and collaborative arrangements with persons and organisations to ‘improve, promote, and protect’ the health of its people, and to promote the inclusion and independence of people with disability. The DHB is also required to gather relevant information and to monitor the health of its resident population. In these ways, these reforms are about devolution of decision-making to a sub-national level of government.

On the other hand, DHBs’ strategic plans must be consistent with the NZHS and the NZDS; and one of the principles of the NZHS is ‘...equitable access for all New Zealanders to a comprehensive range of health and disability services...’ where ‘...the health sector must ensure that New Zealanders with similar health conditions are able to achieve similar outcomes’ (King 2000).

The theoretical literature notes that devolution could lead to efficiency gains from the better integration of services and the improved matching of service with needs at local level, given that local decision-makers will often have better information about needs and services than national decision-makers. It is also theorised that devolution results in more responsive governance and political participation.

On the negative side, it is also argued that there can be a loss of efficiencies because of lack of economies of scale and potential duplication arising from having 21 different agencies purchasing and planning health care, and because of the potential for fragmentation where responsibility for planning is devolved to a local level. In addition, there may also be a reduction in equity of access and outcomes as desired under the NZHS, where 21 different sets of priorities lead to differences in the range, type or level of service available. There are implications for Māori as their Treaty relationships are with central government, not DHBs. There is also potential for confusion over local and central roles, and accountabilities (Mills 1990; Cumming and Mays 2002).

Ministers and officials we interviewed stressed that devolution of responsibilities to DHBs is to occur 'within the national frameworks'. Some informants indicated that there was a belief that devolution would improve health outcomes, though one informant suggested this was 'a leap of faith' rather than a proven strategy. Some officials noted that there is a tension between devolution and the national consistency promoted by the national strategies and the service coverage frameworks. This is seen as a paradox of the model and some suggested that this could be reflected at the local level by frustration at the lack of freedom for real local leadership.

Officials noted that further difficulties are posed by tertiary services that are organised nationally, and for providers delivering services across the country, where services might be detrimentally fragmented and transaction costs increased if they were devolved to the 21 DHBs.

Ministers and officials indicated that devolution was planned as an evolutionary process, as DHBs demonstrate capability. In part this reflects the importance of health to central government, and the political risk of 'getting it wrong'. It also reflects the size and resources of the Ministry, which may overshadow an individual DHB.

One key informant suggested the policy does not devolve funding decisions, but does devolve accountability, advice, planning and monitoring to the DHBs. Some officials lamented the potential loss of capability and tools developed by the HFA to assist with health management as tasks are devolved.

6.11.2 Findings: Devolution

Many of the CEOs communicated a strong perception of a reluctance to devolve on the part of the Ministry, and too great an involvement in operational matters. One pointed out that, while the model emphasises local decision-making, the failure to fully devolve DSS and public health funding means that this objective will not be reached. There was also a feeling that the Ministry has control of the discretionary funds, again defeating the intention of local prioritisation. Key informant officials and DHB informants expected that there would be more devolution over time. However some DHB interviewees were ambivalent about further devolution, noting their limited capacity to manage contracts.

As noted above in relation to the NZDS, DSS funding has until recently remained within the Ministry of Health. Following delays in decision-making, funding for services for those 65 and over is being devolved from October 2003, subject to DHBs showing themselves capable of managing DSS.

Population-based public health funding also remains the responsibility of the Ministry of Health, although DHBs are involved in planning for such services, enabling some co-ordination between local and central decision-making. In a separate project we are currently exploring the reasons why these funds have not been devolved to DHBs and the perceived implications arising from this. This will be reported in a later feedback round.

As far as public health funding is concerned, there was recognition within at least one case study DHB that national funding and organisation is appropriate for some services (such as oversight of screening services) where consistency in practices and in reporting is essential if the service is to be effective.

Some of the comments made during interviews with case study informants reflected concerns about autonomy of DHBs, and hence devolution of both funding and decision-making. One informant noted that the degree of DHB autonomy is limited and in reality, central control is still strong. One case study informant noted the DHB was going to ‘get the accountability for delivering services, but we aren’t going to get the responsibility for making the changes because so much has been prescribed’. The following examples were given by various DHBs:

- In one DHB, the unwillingness of the Minister to sign off the annual plan caused tension, when the Board considered their plan both reasonable and feasible.
- There was a comment in one DHB that central government can still dictate what has to be done and it has to be paid for, eg fertility and surgical services.
- It was noted in one DHB that it is, as yet, unclear where the locus of decision-making lies. DHBs are charged with needs assessment and prioritisation, yet their funding decisions are constrained by national frameworks and (on occasions) interference in local decisions by the centre. It also appears that the Ministry has the discretionary health dollar (eg, for the meningococcal programme), and yet according to the model, it is the DHBs who should be making resource decisions.
- There were comments made about the slow pace of devolving disability support and mental health money; and this was seen that the Ministry was ‘hanging onto the funding’.

- In another DHB it was commented that the Ministry has intervened in contracting decisions. It was suggested that this set a precedent for the future and could be challenging if the DHB has to find the money itself.
- Ringfencing of funding is perceived in one DHB as a major constraint, and although it may be a pragmatic approach for a period of time, it was seen as being used too often and that it should not be there ‘in perpetuity’, for example in mental health.

6.12 Capacity and Capability

6.12.1 Context: Legislative Framework and Policy Expectations

There is a potential for the reforms to fragment scarce resources. This issue was addressed in the legislation by explicit directions to DHBs to ‘actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with the persons in the health and disability sector or in any other sector to improve and protect the health of the people, and to promote the inclusion and participation in society and independence of people with disabilities’ (Part 3, s.23).

The legislation also specifically referred to ‘service agreements’ by which one or more DHBs could purchase services from a person or agency, acting in common (s.25). The development of the shared service agencies (SSAs) was supported by guidelines from the Minister, as specified in the Act (s.24(4)).

Two key informants lamented the potential loss of the technical capability of the HFA and of tools that the RHAs and HFA had developed to assist in managing the system.

6.12.2 Findings: DHB Capacity/Capability

In one DHB it was noted that there is no national capability to provide training – many DHB personnel are still trying to come up to speed in terms of handling contracts, understanding what the national frameworks mean and translating these into contractual agreements. In the same DHB it was also commented that the current model has fragmented the critical mass of expertise that had been formed under the HFA (such as Maori, Pacific and public health expertise).

In one DHB it was noted that new skills were required in a short time frame particularly in the funding positions as this was a completely new area. Upskilling in contract management took time, and in part led to the rolling over of contracts during a capacity building period.

Some NGO providers have also expressed concern that there is no primary care expertise within the DHBs at the senior management level.

It was noted in one case study DHB that the large urban areas present some special issues and require regular inter-DHB consultation. Neighbouring urban and regional DHBs are working through the issues, and relationships are developing. It was reported from this DHB that overall the development of the shared services agency seems to be going well, though its resources are limited. Some services have formed strong links with other DHBs.

In another case study DHB it was noted that collaboration and relationships with other DHBs are developing, but that further collaboration was needed. Two other DHBs also noted that a range of matters were being worked on jointly with other DHBs, for example, public health, human resources, information systems and on clinical matters. One noted there needs to be a willingness to contribute.

The Shared Service Agencies, Regional Mental Health Networks and DHBNZ are more specific ways of coordinating efforts. These are described in fuller detail below and will be followed over the next year to observe how these agencies are evolving.

Shared Service Agencies

Government suggested establishing Shared Service Agencies (SSAs) in the guidelines to DHBs in the implementation phase, in order to promote efficiency, to protect the capacity of the HFA in some technical areas and to ensure small DHBs still had access to more specialized skills. The SSAs are specialised centres of expertise which undertake health planning and funding activities. As regional organizations they perpetuate the HFA locality organization, thus helping retain institutional memory and facilitating the linking of DHB activities.

Four shared service agencies have been established: The Northern DHB Support Agency (NDSA), Healthshare, Central Region Technical Advisory Service (TAS), and the South Island Shared Services Agency (SISSAL). These agencies, owned by DHBs and accountable to DHBs, have a common purpose to support the DHBs by providing planning, purchasing, and contract management expertise. They are governed by DHBs composed of the shareholding DHBs.

The SSAs provide critical mass which is particularly useful for smaller DHBs, helped retain continuity and knowledge during the reform process, and also allowed a contact point for providers during the change period. They also can take advantage of economies of scale and develop regional solutions where that is appropriate.

Each has developed specialist areas of work for which they are recognised, including a research and analysis focus (TAS), service and relationship management (NDSA), change management (SISSAL), and auditing (Healthshare). They also have different governance arrangements. There has been some tension between individual DHBs and regional interests. SSAs can act as mediator in such situations. Alternatively, SSAs can represent groups of DHBs in national forums.

Having become specialised units, some SSAs have sought to expand their organisations by competing for contracts in the open market place beyond their DHB shareholder base. However not all participating DHBs have agreed with this development, as there is a risk it compromises the availability of the SSA to work for shareholders. Since DHBs have stopped SSAs seeking business outside their shareholder base, there is little competition between SSAs. As a result, SSAs have set up strategic alliances with each other to take advantage of the specialist abilities of their sister SSAs.

There is some tension between DHBs over the funding of SSAs. Funds were initially committed to SSAs for only short periods. However the SSAs do not regard themselves as short term agencies, and expect that they will continue to evolve with the ongoing development of the DHBs, for example the development of Primary Health Organisations and population based funding are likely areas of new work.

Case study informants indicate that the development of shared services agencies is seen as going well although resources are very limited.

Regional Mental Health Networks

The Ministry required the establishment of the four regional mental health networks, acting upon the advice of the Mental Health Commission (MHC). The MHC had recommended a regional mental health structure because of the unique characteristics of the mental health sector. These include the *Blueprint* (a national mental health service development plan established in 1998), ring-fenced funding, workforce and skills shortages, the diversity of agencies and the high number of NGOs involved, newly established (or planned) specialist services, and the Mental Health Commission.

The Regional Mental Health Networks are given the task of facilitating the development of new regional specialist services, service planning, quality improvement, workforce development, and promoting cooperation and coordination between different services on a regional basis.

Even at this early stage of development of the Networks, they have adopted quite different organisational structures and objectives, with differing levels of involvement of stakeholders. All four Networks draw up regional plans and generate recommendations on the allocation of additional ring-fenced funds on the basis of the *Blueprint* model of services. All final decision-making rests with the individual DHBs.

According to informants, the mental health sector struggles with problems of acute workforce shortages, poor access to regional services by some patients, duplication of services across some DHBs and gaps in others, low involvement of key stakeholders, difficulties in establishing quality monitoring frameworks, and poor communication between services.

The research identified significant actual and potential problems facing the networks. There are low levels of technical planning expertise, conflict between individual DHBs based on their assessed needs and regional priorities defined by deviation from the *Blueprint*, existing funding inequities within regions, problems around cross-boundary charging and inequitable contributions to regional services, and the potential for power struggles between DHBs and their regional Network.

Although those from within the mental health sector reported benefits, there is confusion amongst sector informants about the purpose of the networks and there are indications that the lack of direct involvement in the DHB governance and accountability structures is problematic, at this stage.

This research was conducted at an early stage of development of the Networks. The diverging evolution of the Networks will be monitored as the research continues, to assess whether the conclusions of this researcher still apply.

District Health Boards New Zealand

District Health Boards New Zealand (DHBNZ) is a collective organisation representing all DHBs. It arose at the early stages of the implementation of the reforms, based on the leadership of some DHB chairs who had been members of the Crown Health Association, a similar representative organisation under the RHA/HFA models. Informants reported that in the early stages there was some uncertainty about the role of DHBNZ. It was reported that the Ministry was reluctant to see a direct relationship develop between DHBNZ and the Minister, and some DHBs were uncertain about whether the organisation was necessary. Across the sector there was debate about whether such an organisation might compromise the decentralised arrangements and merely provide an additional layer of costs.

DHBNZ experienced considerable growth and development in 2002/03, with the appointment of a small core staff, the formalising of a regionally-based governance structure and regular full meetings of all CEOs. The role has changed, moving from assisting the management of the transition, to considering strategic issues on behalf of the sector. Work is ongoing in industrial relations, primary health care, workforce and a number of other areas. DHBNZ works through regional groupings and senior DHB staff, and generally informants report positively on its performance. The role appears to have expanded into a more formal relationship with government, constructive interaction through a memorandum of understanding with the Ministry and a negotiating role on behalf of the sector. This last role is clearly appreciated by most DHBs, but with occasional low key warnings that this must not compromise individual DHB decision-making. For example, one chair commented:

‘...it’s in danger of galloping too fast at the moment...and I think DHBNZ has to be pretty careful that it doesn’t start to see itself as the voice of all DHBs. If they [DHBs] are going going to have any relevance and meaning they have to be able to make some of those decisions for themselves’.

6.13 Adaptation of the Ministry of Health to New Role

In the Board member survey, almost 60% of respondents agreed or strongly agreed that the Board needs more support from the Ministry and the government although it is not clear what form that support should take.

Most CEOs reported that their relationship with the Ministry was either good or improving. They acknowledged the difficulties the Ministry has had in implementing the reforms in a relatively short time period, and there was high regard for senior Ministry officials, some of whom had been very supportive of CEOs individually. There was a strong perception of a reluctance to devolve on the part of the Ministry (one CEO commented ‘the empire strikes back’) and too great an involvement in operational

matters. Several CEOs reported excellent relationships with account managers, but a need for improved co-ordination, and reduction of 'single issue desks'. There is an expectation that over time the Ministry and DHBs will develop a more appropriate relationship based on their statutory roles and responsibilities.

Relationships between the Ministry and DHBs are seen as good in the case study DHBs, even if they are strained at times. In one DHB, good relationships were attributed to a politically astute chair and key management personnel who pre-empt potential problems and talk to key people in the Ministry. From this same DHB the comment was made that the Ministry has been supportive in tough times. For one DHB, the posting of guidelines for community consultation on the Ministry website was seen as a positive initiative, providing the history of health consultation and helping translate it into the new environment. In another a comment was made that the Ministry has a good skill base and an overview of where the health gaps exist.

However, a range of negative comments were also made about the Ministry and its role. Comments include (and in general these come from a number of DHBs):

- There is insufficient time for responses and feedback from DHBs to the Ministry on key documents.
- There is slow turnaround by Ministry of DHB documents and plans, particularly annual plans and strategic plans; the Ministry needs to recognise that DHBs require timely information and faster turnaround of documents.
- There can be duplication, fragmentation and a lack of communication within the Ministry which means DHBs do not get consistent messages, are asked to duplicate work for different sections of the Ministry and do not have clear reporting responsibilities.

- At times there is insufficient consultation – directives are sent without prior consultation or notice.
- In one DHB, there is a perception that some policies from the Ministry lack consultation and are framed as ‘you shall do this’, for example the operating policy framework. In this same DHB it was commented that the Ministry needs to understand that each DHB has some different processes and procedures.

Overall, the Ministry is seen as too bureaucratic and prescriptive; focusing too much on operational issues and ‘micro-managing’. This is seen to stifle flexibility and innovation at a local level.

Some of the comments reflect concerns about autonomy of DHBs (see Devolution, above). In one DHB it was noted that the amount of autonomy the sector has is debateable and the reality is it is still centrally dictated. Another case study informant noted the DHB was going to ‘get the accountability delivering services, but we aren’t going to get the responsibility for making the changes because so much as been prescribed’. A number of examples were given earlier, leading to DHB concerns around autonomy.

In two DHBs, the comment was made that central government priorities are not always the same as local priorities and can create tensions. Local innovations can sometimes be at odds with the need for national consistency. This same DHB commented that national standards should be set before devolution. It was commented that the Ministry can cut across and not fully understand the role of the DHB and the planning of services.

There is a perception that the Ministry has a large resource that has changed little; that it has not shifted from funding back to policy and not upgraded its skills to reflect this change. For example, one case study informant commented on monitoring, which was seen as important, but also as an undeveloped skill set. In one DHB the feeling was expressed that the Ministry is not downsizing and taking on a new role, causing tension

and conflict. In another DHB, the comment was made that the Ministry should downsize and focus on strategic direction. In one DHB it was commented that DHBs look to the Ministry for strong leadership, a co-ordinated approach, strong policy development but not interference in implementation. One informant commented that Ministry staff would benefit from experience outside the policy field, spending time working at the implementation and DHB level.

In one DHB it was suggested that workforce planning and development, particularly for Māori, needs national rather than local attention. In another, the comment was made that DHBs are ‘all working in a bit of a vacuum’. There is a need to advertise successes around the country, and to understand what works, particularly in the area of integration.

6.14 The NZPHDA Model

6.14.1 Context: Theoretical and Policy Expectations

The number and location of the DHBs were largely determined by rolling over the existing structures, the HHSs. Some officials noted that there is a trade-off between the economies of scale and having DHBs close to a local population. Geographical boundaries also naturally define some communities. There is a broad view from government and officials that 21 DHBs is more than would have been chosen if the system was established afresh. Enabling voluntary amalgamations and encouraging cooperation between DHBs were seen as two solutions to this.

During our key informant interviews, concern was expressed by some officials and others that the model was flawed in combining the roles of provider and purchaser in the same organisation, as this confuses the decision whether to buy or make services. Similarly, officials and others indicated there had been concern during the setting up phase that the model needed to overcome the dominance of the hospital and re-orient to primary health to achieve the larger objectives.

The Strategies were characterised by one key informant as a way of the Government shifting focus from outputs to outcomes, from efficiency to quality, and from hospital domination to improving population health.

6.14.2 Findings: The NZPHDA Model

In the survey of Board members, many respondents (63.1%) agreed or strongly agreed that their Board is performing well. Generally case study informants felt DHBs are still learning and settling into the new system and thought it too early to comment on performance.

Overall CEOs saw more strengths than weaknesses. The major reported strength of the new arrangements is bringing funding together locally. The involvement of the community in planning and decision-making is seen as a strength, allowing both responsive services and the management of expectations. In terms of policy orientation, strengths are seen in the move away from a commercial towards a ‘social responsibility’ ethos. Co-operative approaches between DHBs benefit both large and small DHBs alike.

The major reported weaknesses of the new structure, from the CEO perspective, are the presence of elected members, higher than desirable levels of central control, and the transaction costs of a cumbersome governance structure and large number of DHBs.

However, most of the weaknesses were seen as manageable by CEOs; irritations rather than features that seriously undermine the system. Major change was not recommended (‘just buff it up a bit’) and many CEOs anticipated improvements (eg. in relationships with the Ministry, involvement of elected members) over time.

The following strengths of the model were identified in the case study research, the first five mentioned frequently:

- The ability to look regionally at the needs of the population. Even with some constraints it is considered a 'big advantage' to have total funding for primary and secondary care, and across the continuum of care, and to be able to broaden the focus to include public health and population health concepts, away from the 'bottom of the cliff' approaches that characterized the CHE model.
- The ability to involve community in decision-making.
- The opportunity to be more locally responsive; in particular for the opportunity for better local planning and better local relationships.
- The ability to plan more effectively for the local population.
- Enhanced engagement with providers at the local level.
- The focus on inequalities, although a comment was made that the government has been negligent in trying to explain this to the community.
- The increased focus on primary health care.
- Increased transparency (eg clinical priorities with national waiting list model and finances) promotes more honest public expectations.

In one DHB it was noted that there is a strong sense that the model is evolving over time. It was also suggested that historical factors continue to exert a powerful impact, particularly on funding priorities and philosophy, although overall there appears to be a genuine desire to move to a more local DHB approach. In one DHB the reforms are beginning to influence the culture of the institution eg improvement was noted in devolution of responsibility to clinical areas.

In another DHB it was noted it was too early to say if the reforms were ‘working’, but almost all those interviewed felt that the model built positively on the reforms of the past. Time was now needed to bed the reforms in and ‘fine tune’ where necessary. In another DHB it was felt that DHBs are still on a learning curve, and it is still too early to comment on performance. In one DHB, several respondents commented the sector needs ‘no more paradigm shifts’; rather, what is needed is incremental developments.

Some weaknesses with the model were also noted in case study research; these have been discussed throughout this report. In particular, there were frequent comments that there are too many DHBs, which is seen as creating duplication of effort and increasing boundaries issues. Unless there is extensive regional commitment to collaboration, amalgamation and rationalisation is seen as highly likely.

7 Summary and Issues for Follow-Up

The Research Team has very much appreciated the high level of cooperation from all those approached for information, especially people in the five case study DHBs. This is demonstrated by reflective interviews and timely, and ongoing, provision of documents.

Overall, there is support for the NZPHDA model. A number of positive features of the model have been identified and commented upon by a range of people working in the sector. There is a strong sense that the model is evolving over time, with those working in the sector learning and settling into new roles. However, we have noted a number of issues that are raised by our research to date. These issues stand out, either because of the consistency of message across data sources and districts, because of the strength of the comments made, or because key points have been raised about important parts of the model. In this section of the report, we summarise the key points raised in the research and note some suggestions for follow-up research, some of which will be undertaken by the Research Team during 2004.

Governance

It has been noted that there are low numbers of Māori elected to Boards, and no Pacific members were elected to Boards. A single transferable voting system was seen by some in the sector to be one approach to remedying this at the next election. If there were further development of strategies prior to the 2004 elections to promote Māori and Pacific candidates and/or to have more candidates elected to Boards, a review of the effectiveness of such strategies following the 2004 election would be informative.

Support has been expressed for having appointed members on Boards to fill gaps in skill mix, but informants have also reported a lack of transparency in the appointments process. There is a concern about the possible destabilizing impact that high turnover of elected members might mean following the next elections. A review of the turnover rate and the impact of this on Boards would also be informative following the 2004 elections.

A number of different approaches have been taken to organising the DHB Statutory Committees. There is concern that the governance structure, with three statutory Board committees, is excessive and costly to support. It would be useful to identify whether the different approaches used in different DHBs result in different outcomes, in for example different levels of engagement with the public; different levels of understanding of the issues in the community; different allocations of resources, resulting for example from possible domination of hospital issues through the combining of committees; and different levels of administrative cost.

Strategic Decision-Making

DHB Planning and Funding Managers were positive about the benefits of the Health Needs Assessments for planning. However, there was not always a good connection between prioritisation, district strategic plans, district annual plans and budgeting. As a further round of planning is undertaken, further research could be undertaken to identify if the connections between these processes improve over time.

Implementation of Key Strategies

Respondents to the survey of Board Members did seem to reflect the broad objectives of DHBs set out in legislation and the priorities set out in the NZHS, NZDS, PHCS and *He Korowai Oranga/The Māori Health Strategy*. The seven DHBs with significant Pacific populations did not seem to reflect Pacific health issues by scoring Pacific health issues more highly than other DHBs. As DHBs go through a further cycle of planning, it would be useful to understand how NZHS, NZDS, *He Korowai Oranga/The Māori Health Strategy*, and the *Pacific Health and Disability Action Plan* and DSP priorities become translated into DAP priorities, and into budget allocations and changes in the mix and volume of services delivered. This will enable further evaluation of the implementation of government strategies.

Some parts of the health sector appear to be confused in their understanding of the NZDS and some DHBs appear to have been slower in recognising the sector's responsibilities in implementing the NZDS. The role of the DSACs has been unclear. With funding allocated to DHBs from October 2003 for DSS for those aged 65 and over, further research into the roles that DHBs and DSACs play in relation to the NZDS and in relation to DSS would provide an indication of how the NZDS is being implemented in DHBs, and the role that DSACs can play in the sector. The separation of services for older people's services from those delivered to younger people may bring its own problems and this will require careful oversight over the next few years if all services are not devolved to DHBs.

Purchasing and Contracting

The initial round of devolution of contracts was problematic because the DHBs were not provided with adequate and timely information to undertake due diligence. The national stakeholders interviewed so far (mostly national NGOs) reported mixed impressions with some DHBs being seen as still locked into the "old ways of contracting" whereas other DHBs, particularly the smaller ones, are seen as becoming much more dynamic and innovative, despite their lack of capacity. As contracts come up for renewal, research should focus on whether and how DHBs change the way in which they contract.

Treaty of Waitangi and Māori Health

The inclusion of the Treaty of Waitangi in the *New Zealand Public Health and Disability Act 2000* provided a significant platform for DHBs and Māori to work from to improve Māori health outcomes. Although there was disappointment that the manawhenua clause was not enacted, at the DHB level the relationship is often with *manawhenua* anyway. The *manawhenua* in four of the case study sites have included *taurahere* or *mātāwaka* in the governance level arrangements. Some DHBs have also established links with local iwi and Māori communities.

The Act has also enabled the appointment of two Māori Board members on each DHB if the election process fails to achieve an adequate level of representation. Given that the election process did not work well for Māori, there is a need to further develop strategies prior to the 2004 elections to promote Māori candidates and/or to have more candidates elected to Boards, and to review the effectiveness of any such strategies following the 2004 election would be informative.

However the new local Treaty relationship raises concerns for Māori as the implications of this new relationship are unclear. Some thought it a subtle shift of responsibility away from central government. The allocation of resources to Māori providers at a local level also raised concerns as traditionally Māori have not fared well at the hands of local government.

He Korowai Oranga/The Māori Health Strategy and Whakatātaka/The Māori Health Action Plan were launched in November 2002. There was concern expressed that DHBs may have different levels of commitment to it. Some informants doubted its potential to bring about real gains in Māori health. It was thought that a strong committed approach to its implementation is necessary if the Strategy is to be effective.

The notion of *whānau ora*, while being a strengths-based approach, requires DHBs and mainstream providers to revisit and rethink the way in which services are delivered to Māori. At the moment services are delivered on an individualistic pākehā model of healthcare. It has been suggested that *whānau*, *hapu* and *iwi*, should all have direct input into service planning and delivery.

While the development of PHOs was seen as positive because of increased access to primary care, it was noted that there are risks for Māori health providers. Those interviewed believe the unique services they provide must be protected.

Pacific Peoples and Pacific Health

Recent health reform is seen in a positive light for the Pacific community and providers. Although it is seen as an evolution of previous models, it is positive in terms of the non-competitive model for the providers, development of *The Pacific Health and Disability Action Plan*, selecting specific DHBs with high Pacific populations to become priority DHBs, and encouraging Pacific issues to the forefront.

There are issues that need further research and analysis based on the interim findings. They include DHB consultation with community/providers and the processes involved with this; workforce development and the career pathways and employment issues for Pacific people; PHOs and what they mean for Pacific communities; and DHB monitoring of the contracts. There is a need to examine in detail across the DHBs that are priority DHBs.

The research that is being presently undertaken has provided the Pacific peoples with a rare opportunity to voice their opinions about the changing reforms. It is trusted the research results will aid in the policy decisions that will achieve better health outcomes for the Pacific population.

Devolution

There is a strong perception of reluctance to devolve funding and decision-making on the part of the Ministry of Health. As it has been implemented to date, a degree of central planning and purchasing remains within the model. While DSS funding for those 65 and over has only recently been devolved, population-based public health funding remains the responsibility of the Ministry of Health, with DHBs involved in some planning and coordination between local and central decision-making. It is important to monitor the impact such splits in decision-making responsibility might have on overall planning, coordination of services, and the ability for DHBs to meet local needs.

There is also a need to ensure that costs of co-ordination from shared arrangements do not offset the benefits gained by having a degree of regional or central decision-making in the system.

Capacity and Capability

The current model is seen by some to have fragmented the critical mass of expertise that had been formed under the HFA, leaving DHBs with a lack of capacity for many of their assumed or prospective roles. DHBs are developing working relationships with each other, including at a service level, and the SSAs seem to be working well. There is less clarity over the role of the Regional Mental Health Networks and some concerns that new funding for mental health was allocated regionally.

DHBs are establishing joint working relationships, in part to overcome some of the potential capacity/capability and fragmentation/duplication issues raised by the model. There is a need for on-going review of how these relationships develop, their sustainability and the implications for the model of having, or not having these, relationships. The issues raised by shared arrangements to date include a need for clarity in the roles of joint agencies, and about where final decision-making ability lies about how to spend resources.

Adaptation of the Ministry of Health to a New Role

DHBs clearly see that the Ministry of Health/Minister of Health as being involved in decisions they believe they ought to be able to take for themselves. We note however that some of the decisions here may be taken by Government as opposed to the Ministry of Health, but it is the Ministry that is perceived by DHBs as responsible for resisting devolution. Nevertheless, DHBs are clearly concerned that the model is not being implemented as perhaps they might have anticipated. We note that there is potential for wasted effort by DHBs, frustration amongst DHB Boards and staff and DHB populations, and poor matching of local services to local needs as a result.

Some tensions will always be expected, and even welcomed, in relation to the role the Ministry plays in setting performance expectations and monitoring the performance of DHBs. However, New Zealand's small size and limited capacity, means that the Ministry and DHBs will always need to work together well. Clarity over the type of decisions that DHBs can take is required in order to ensure the respective roles of the Ministry of Health and DHBs are understood and that resources are allocated appropriately as a result.

Perhaps paradoxically, the research to date has also identified a desire by some in the sector for more support from the Ministry of Health, for example in training in priority setting and contracting, and in relation to Māori Health and Pacific Health.

NZPHDA Model

There is general support for the model and moreover, major change does not appear to be recommended at this stage. This may be in part related to 'change fatigue' and a desire to let a new structure settle in and evolve gradually rather than be subjected to further disruption, but also seems to be a reflection of overall support for the model. Many believe, however, that there are too many DHBs, leading to high transaction costs and too much duplication of effort. Some expect amalgamations, although no DHBs are yet 'putting their hands up' to amalgamate. As noted above, DHBs are developing a number of ways of working together; assessment of the effectiveness of these approaches will provide us with information about whether local decision-making agencies can work where there are good joint working relationships.

Some in the sector are also worried that PHOs, set up under the PHCS, also add an extra layer of bureaucracy, further increasing 'management' costs in the sector. Smaller NGO providers are also concerned that PHOs will 'take over' their organisations or roles, in order to reduce transaction costs or expand their own roles, resulting in a potential loss of flexibility and innovation that smaller providers are seen to bring to the sector.

Currently, there are a large number of different agencies involved in the health sector; some are small and hence add to the management/administration costs in the sector, but they are often felt to be innovative and dynamic in meeting the needs of their communities. There is a concern that these smaller agencies will lose their identities, perhaps reducing overall management/administration costs, but at a cost to innovation. There is a need to closely monitor developments in this area, to identify the types of services that deliver good outcomes and best meet local needs cost-effectively, and to ensure that decision-makers consider such issues when deciding how to have services delivered in their regions.

8 Summary of Discussions Following Feedback Sessions

As formative research, the interim results have been fed back into the sector as they come to hand, to inform the sector as the reforms evolve. These sessions have included the CEOs and Chairs of DHBs, key Ministry of Health officials, DHBNZ, and the Minister and Associate Ministers of Health. Separate sessions on the implementation of *The Primary Health Care Strategy* are planned for later in 2003, following the completion of a separate piece of research.

The discussion following each feedback session has been recorded in note form. In many instances the discussion focused on the gaps in collective knowledge and pivotal aspects of the reforms. Where possible the research team representatives answered the questions based on the information available, but also took note of the areas of concern, as a “barometer” of opinions and as an indication of topics of interest. The ongoing research will be able to address some of these topics, although some will be beyond current available funding and time frames. The audiences were also able to contribute from their experiences and knowledge, to endorse the findings or to contribute other perspectives. This has meant the feedback sessions are a two way process: both informing the sector and giving another source of information to the research team.

Recurrent themes in the discussion were questions of how the reforms, collectively and on particular aspects, impact on clinical outcomes. The research team reiterates that such research questions are beyond the scope of this project to answer directly. However it is also understood that these questions are a fundamental rationale driving the reforms.

The notes taken at these feedback sessions from 28th May to 4th August have been collated and are shown here, as indicative of the interest in the sector in these research results and the process of formative research in action. The discussion notes have been grouped by theme and also by the category of “Gaps in information gathered so far”.

Electoral Issues for Māori

Members of the audience endorsed and acknowledged the reported research findings on the difficulties with the electoral system for Māori. The lack of transparency with the appointment process, which is meant to compensate for the gaps, risks further perpetuating mainstream structures. Having two Māori members on Boards by mandate is a positive gain, but they still represent a minority voice.

In a number of discussions the question was raised whether STV will provide better electoral representation for Māori.

Statutory Committees

The cost of running committees was acknowledged to be a concern by those involved with DHBs. The research team was asked about the costs of governance, particularly the committees, and whether there are any moves to trim these back.

Transparency

Few members of the public, other than researchers and the occasional media representative attend Board meetings, with just a few exceptions.

The ways that DHBs cope with having meetings open to the public were noted as some of the same solutions that Local Government uses, that is, workshops and closed committee sessions to discuss some issues out of the public eye.

Health Needs Assessment (HNA) and Prioritisation

There is keen interest in how the Government's identification of key priority areas (as listed in the NZHS) and the HNA/planning cycle, carried out at the local level, translated through to gains in health outcomes in the DHBs populations. The lack of capacity and lack of capability to do the HNAs was acknowledged as an issue of concern.

Some of the questions about HNAs that have been raised in the discussions are:

- How sensitive is the quality of that planning work to the manner in which the HNA was carried out? For example, some DHBs used an external consultant and the HNAs were done to a formula, but does that lead to a different quality of output compared to a customized HNA process drawing in local knowledge?
- Where separate HNAs were done for Māori, what difference does that make to strategic planning for Māori?
- Will the research drill into depth to examine HNA expenditure decisions? An audience participant expressed a concern that, if the DHBs do not buy into population-based provision and funding, then there is a threat to the population health priorities strategic approach.

Primary Health Care Strategy

Audience participants acknowledged that there have been implementation difficulties with the PHCS, but also expressed uncertainty about how guidance to the sector could be usefully improved upon.

A participant noted that in the United Kingdom, GPs initially dominated the primary care trusts but then other professionals moved in. The same trend may happen here. The rapidly evolving nature of the PHO sector was acknowledged by researchers and audience participants.

The possibility/risk of IPAs making superficial changes to the governance structures to re-invent themselves as PHOs, but defeating the spirit of the reforms, was mentioned as a concern by one audience participant.

Audience participants and researchers observed that there is a risk that PHOs introduce another layer of bureaucracy with associated costs. There is also a risk of loss of dynamic efficiency if contracts/providers are bound into PHOs. Smaller providers were observed by some audience members to be more likely to take some risks and therefore to be possibly more innovative.

Audience participants expressed the hope that the access formula used for the PHOs will target the people in need, and also noted that PHOs were unproven as yet at improving health outcomes for Māori, while possibly threatening Māori provider organisations. IPAs are well resourced, given their history, but Māori PHOs are not well resourced, so that they then have to “tax” the providers to cover the administration costs, which IPAs have already covered.

Audience participants and a researcher noted that, with regard to PHO development, in at least one area there has been arguing over contracts with provider organisations. Neighbouring areas may have different access formulas, which creates boundary issues, with patients being attracted to the PHO which offers the cheapest care.

Regional Collaboration

An audience participant asked how far has regional collaboration penetrated through the levels of organization and governance structures, for example whether it went as far as joint purchasing or into joint arrangements for service delivery. Researchers noted that there are some examples that show penetration to service delivery level, e.g. in mental health.

Some discussion flowed between DHB Chairs in relation to amalgamation, which was not seen as the answer. Instead, regional collaboration was favoured. Auckland was acknowledged as the area to watch to lead the country in regional collaboration. It was noted by one participant that they have established a range of collaborative mechanisms (Anderson, 2003), and also with regard to their Regional Mental Health Network are ahead of the rest of the country.

Māori Capacity and Capability

Audience participants expressed the concern that the already slim Māori expertise is spread even more thinly if devolved to 21 DHBs. The parallel was drawn with public health resources. Not all DHBs have Māori expertise. Participation, particularly in a formula driven model, e.g. with prescribed minimum numbers determined by legislation, may not equate with health gains. PHOs have governance requirements to include Māori representation, but if there is not the capacity, then it cannot be operationalised, and risks tokenism.

Audience participants also asked about research evidence for this Māori workforce capacity having been spread thinly, as feared. The researchers responded that the impacts on capacity are too early to say. However, discussion focused on the DHBs' small margins and inherited deficits which may contribute to erosion of workforce development.

It was noted by a participant that the Auckland shared service agency, the Northern DHB Support Agency, is possibly involved in looking at Māori health and workforce issues. Succession planning is another issue, e.g. where there are one or two key personnel in a small Māori provider organisation, there is a risk of it imploding.

Māori Providers

An audience participant noted that provision by Māori for Māori, is assumed to generate better outcomes, as compared to mainstream provision for Māori. The evidence to support this assumption (hypothesis) needs to be collected. Although the health outcomes data is outside the scope of this research, the links between Māori representation, planning, Māori provision and what happens in this merged purchaser/provider system can be examined.

In discussion, participants expressed concern that the DHBs' focus on deficit reduction and managing hospitals may detract from Māori development.

Some of the vulnerabilities facing Māori provider organisations were discussed by audience participants. Māori providers are often small scale and spreading themselves even more thinly to contract with PHOs and DHBs, with high transaction costs. There are risks to Māori provider organisations of DHBs "bulking up" provider contracts, driven by costs and ease. In seeking economies of scale, Māori provider organizations, small PHOs and allied professionals are at risk of being adversely positioned. The health reforms are seen as threat to providers, arising from the fact that DHBs have a provider arm themselves, including Māori providers, which are in a competitive relationship with non-government Māori providers. Although the DHBs now have a greater incentive to strengthen community service delivery, they have a choice to buy or make services. The research team acknowledged these concerns but also pointed out it is too soon to show the evidence for this.

It was noted that contracts between DHBs and Māori provider organisations ignore iwi boundaries.

Māori provider organisations will be deciding whether they join a PHO or not. It was noted there are some risks from joining. Per capita funding for small providers is seen as insufficient to cover infrastructural costs. There is provision in the legislation that Māori providers need to be supported to provide for Māori patients. However some of the audience participants expressed the view that this was ‘too weak’.

Other Provider Organisations

Audience participants noted that NGOs had to move to a central focus under the HFA system and now are having to re-organise themselves regionally again.

In discussion, participants acknowledged that it is more expensive to contract with lots of providers, which may be an incentive for the DHB to bundle up contracts. Marker indicators of changes may be loss of Māori provider organisations; and community providers being less innovative.

One audience participant pointed out that providers are funded in arrears, on a year by year basis, which does not allow for good forward planning.

Devolution

In one of the feedback sessions, the tension between the Ministry prescribing what services DHBs deliver to avoid perceived political risk versus devolution and local decision-making was seen as a realistic dynamic to be managed. It was also acknowledged that the coalition government increases or broadens the political risk to be managed.

One participant acknowledged that devolution does fragment the expertise and that this is a point to watch.

With regard to devolution, the distinction was made between devolution of risk and devolution of decision making. One DHB CEO commented ‘there is plenty of devolution of risk, but not much of decision making,’ which drew a strong response of agreement around the room.

Media Representation of the Health Reforms

Media orientation to hospitals was acknowledged as perpetuating the “old” culture. It was observed that the prominence given to hospitals and reducing waiting list in the public survey is at odds with the spirit of the reforms. Whether there is a shift in public opinion with time will be a point to watch in a later survey.

Māori Health Outcomes

Have improved outcomes for Māori come through in reporting data yet? At least one DHB considered they are making significant gains, and was keen to see this registered in outcomes. The PHO model was also seen as likely to make a useful contribution.

Performance Management

Audience participants observed that some of the requirements imposed on DHBs, that evoke criticism of the Ministry of Health, were actually the actions of the Ministers.

It was confirmed by one audience participant that some Māori provider organisations were audited by HFA, then audited again, then by the Ministry on top of it, so they were audited two or three times in the end. The organization holding the contract determines where these reports are sent, but concerns were raised that often providers do not know what happens to the reports.

The Treaty and Health Reforms

An audience participant stated that:

'manawhenua has the strategic relationship with the DHB, that is in the constitution. If DHBs are clear about their relationship with the *manawhenua*, then that shouldn't create tension, as long as *mātāwaka* recognize also that it is the *manawhenua* who have the strategic constitutional relationship with the DHB. It is not about numbers, it is the constitution. The *manawhenua* and *mātāwaka* have to work out their relationship'.

In relation to elections and appointed members, an audience participant shared their knowledge of the process: *Rununga* were consulted, and asked for lists indicating who could best represent them. Potential representatives were put through an interview process, to gauge skill and experience in a governance role. Candidates were then ranked. More training for governance and capacity building in Māori was thought to be an issue by this participant.

Interest was expressed by an audience participant about how well shared decision making occurs. For example, the *manawhenua* in Mid Central DHB have been well consulted. Will the decisions in relation to DHB priorities reflect *manawhenua* preferences?

He Korowai Oranga/The Māori Health Strategy

Researchers discussed with audience participants the perceived strengths and weaknesses of *He Korowai Oranga/The Māori Health Strategy*. One participant pointed out information gathering occurred before implementation of *Whakatātaka/The Māori Health Action Plan*, and the final version of the Strategy.

The concept of *whānau ora* generated considerable discussion amongst participants. Issues relate to the lack of definition of *whānau ora* and the fact that the health sector monitoring is set up for individuals. Strong cultural identity is part of *whānau ora*. At a *hui* in Rotorua, of pharmacists, *whānau ora* was defined in terms of identifying the best way of delivering services. For example, if a practitioner is prescribing medicine, he or she needs to identify who in the family would best ensure medicine compliance and involve that person.

Another view expressed by an audience participant was that an implication of the emphasis on *whānau ora* is that funding should increase for public health, as that is where the *whānau* is.

It was also commented that research should contribute to building onwards, and there is a risk of getting trapped into defining *whānau ora*. There are issues burning away in the background e.g. higher incidence rates of rheumatic fever for Māori and Pacific people as compared to Pākehā. The sequellae of rheumatic fever is heart disease and kidney disease, yet this disease is not on the policy agenda; we need to ask why not?

Dynamic Efficiency, Innovation

Researchers noted that one of the surprises of the research is that smaller DHBs, which had been expected to struggle, actually may be a source of innovation. This finding generated interested comment and inquiry from the audience.

NZPHDA Model

Generally, researchers have found the sector is positive about the model. Audience participants discussed this finding. Generally there was a consensus that people like the local focus, which includes the community involvement, plus they are sick of change.

One of the DHB CEOs asked whether there were any surprises in the data, to which a researcher responded that the biggest surprise is how positive everybody is about the model.

Interest was expressed in one forum about the impact of these research findings on the Minister and the Ministry of Health, asking, what changes will emerge as a result of the research? Researchers noted they will have the opportunity to ask about this in interviews in 2004.

One CEO observed that the structure of DHBs was initially with separate management arms for purchasing and provision but there is now a shift to integrated management structures.

Issues for Follow Up

1. The impact of the HNA process on decision making. The strategic targeting of health funds rests heavily on that process, given the lack of differentiated funding streams. The ongoing research will strive to capture this.
2. The making vs buying of services. What is the effect of the DHB having a provider arm? Whether this impacts on decisions relating to the extension of contracts to providers, and whether that influences the volume and mix of services will also be monitored in the ongoing research.
3. The coincidence of the Employment Relations Act and DHBs. Possibly the increased power of doctors and nurses in the labour market has put upward pressure on the deficit. Also this may have an adverse effect on Māori provider capacity as nurses may be attracted into the hospitals by better wages. DHBNZ has looked for collective agreements to avoid ratcheting effect. Another commented that senior medical officers, by pricing themselves out of the market, have been a force towards innovation and greater use of other ancillary professionals. The ongoing research will

look at the impacts of the reforms on workforce issues, including the impacts of devolution and changes to provider organisations. However, the impacts of the larger policy context are outside the scope of the research.

4. The three year funding path, and the population based funding formula: How do these impact? This will be examined in the five case study DHBs.
5. Appointment processes for Māori, and the acceptability to the Minister versus acceptability to the community are acknowledged to be issues of concern, as are the time it takes to appoint, and the role of chairs in this process. These topics of interest will be expanded on in the ongoing research.
6. What would enhance the electoral process? Particularly for Māori, who traditionally have low numbers voting, then the few nominees are unlikely to be voted in as non-Māori usually do not vote for Māori. It would be possible to ask Māori providers for nominations but then Māori provider organisation vs iwi vs other representation networks are put into conflict. This is noted as a topic of interest but is outside the scope of this project.
7. Would STV result in a more representative mix of elected members?
8. DHBs: do they allow small providers or do they look for large providers? The only new money is going into PHOs. It is thought a lot of contracts have just been rolled over, but that essentially means a shrinking of the budget as it would not absorb cost increases. The provider organisations will be watched carefully in the ongoing research in the five case study DHBs.
9. Devolution. What are the advantages? Look for the reasons and evidence beyond “we want the money”. Reporting data is confounded by the money put into primary care. However this question regarding devolution will be considered in the ongoing research.

10. Comparison with other models. This will be done by combining information from:

- Treasury analysis of models
- Interviews with long term employees
- Data, although time series data is problematic because of confounders
- Māori providers- look for evidence of more money or less? Growing or shrinking? Contracting is a useful source of information. When was the last time had an increase in service funds?
- PHOs capitation system vs NGOs, MPO contract lump sum also would allow some comparisons.

This comparative analysis will be included in the ongoing research.

Appendix 1

Summary of New Zealanders' Views on the Health System 2001

1 Introduction

A survey was made of New Zealanders' attitudes and views on the health system, current District Health Board (DHB) reforms, and key aspects of current New Zealand health strategies.

2 Method

A telephone survey was carried out by BRC Marketing & Social Research. A random sample was taken of New Zealanders listed on the General Electoral Roll, and Māori were selected in a booster sample using the Māori Electoral Roll. The response rate was 40% (39% for non-Māori, 44% for Māori). The fifteen minute telephone survey of 504 New Zealand citizens, including 95 Māori, was conducted in June-July 2001, at the beginning of the reform process.

3 Key Findings

- Optimism that DHBs would bring easier access to hospital services, and that they would consult with the public.
- Medical professionals and local members of the public were the preferred types of people to be District Health Board members.

- Māori people, Pacific people and people with physical disabilities were also acceptable.
- Most respondents agreed that setting budgets and deciding what services should be available, and especially consulting the public, were suitable activities of DHBs.
- Over three-quarters of respondents would like to have their say by voting for DHB members, but at the same time most respondents did not spontaneously suggest DHB members as the kind of people who should make decisions about health services.
- Fifty-eight percent of respondents wanted an increase in government spending to help people stay healthy (primary care/ preventative services), while maintaining current spending on hospitals.
- Of those wanting increased primary/preventative services plus current secondary services, 53% favoured paying for these by encouraging people to have private health insurance.
- Most respondents were opposed to Government paying for increased services by increasing user charges (79%).
- Satisfaction with overall health services was poor, with 46% either dissatisfied or very dissatisfied. This was higher for Māori (51%).
- As in previous surveys, waiting times and costs featured as reasons given for dissatisfaction, but those respondents who cited personal/ family/ friends' experience as the main reason for their rating were more likely to be satisfied. Waiting times were of particular concern to respondents.

- The key aspects of current health strategies were each rated important or very important by respondents, the highest rating going to reducing waiting times for public hospital treatment, and the lowest to enabling people with psychiatric disabilities to live in the community.

Available press reports from 2000 to mid 2001 were scanned. There was considerable press coverage of DHBs. The form and processes of establishing DHBs were closely followed and there has been comment especially on costs.

Appendix 2

Preliminary Analysis of Key Informant Interviews

1 Introduction

The aims of these interviews were to establish expectations of the reforms, including the major goals of the reforms and the issues key informants expected to arise from the NZPHDA model (hereafter, called the model); to provide information on the rationale for policy decisions taken in setting up the model; and to provide information on early implementation processes and experiences. This information also assisted the research team in identifying any significant issues not already included in the research plan. Non-Māori and Pacific key informants were also asked about Treaty of Waitangi, Māori Health and Pacific issues; these are reported separately in the main body of the report.

This preliminary analysis consists of three sections. First, we discuss the methods used to collect and analyse the data. Second, we report findings relating to the goals and expectations of the NZPHDA model. Third, we report on the implementation process and early experiences of how the model was working at the time of the interviews.

2 Methods

Key informants were chosen for their role in formulating policy or implementing aspects of the model, or as important commentators on health policy. Interviews were undertaken between February and May 2002. The same groups of informants will be interviewed in early 2004, to discuss progress and to identify any issues that have arisen from the Model since our earlier interviews.

The research team drew up an initial list of key informants, and a snowball technique was used to identify additional people who might be able to comment on the background to or implementation of the model. In all, nineteen interviews were undertaken with seventeen key informants. These included government Ministers and advisors (four), opposition spokespeople on health (three), senior officials from the Ministry of Health and Treasury (eight) and senior officials from the Health Funding Authority (two). Where possible, interviews were face-to-face, otherwise interviews were conducted by telephone. Semi-structured interview schedules were developed to guide the interviews. Interviews were taped with the interviewee's permission, and tapes transcribed, checked and returned to interviewees to make any desired changes. Where interviews were not transcribed, notes were taken, written up and returned to interviewees for checking. Data were analysed by a process of thematic analysis. All transcripts were entered into an NVivo database. Themes were agreed by the research team. Transcripts were coded by theme by two people, the data separated out into themes and sub-coded.

As the main purpose of these interviews is to identify the issues key informants see arising from the model, we have not always clearly linked different perspectives to different groups of interviewees. Where direct quotes are used, an interview code follows, thus KII 1 refers to key informant interview 1.

3 Findings

3.1 Goals, Expectations

Context and Rationale for the Reforms

The main driver for the reforms came from the Labour Party's health policy as set out in its manifesto for the 1999 General Election. The government's health policy objectives drove the reforms from the outset. One Ministerial advisor noted that, for the Labour Party, health is a fundamental social service, and that Labour believes that a health care system will only work if the community is involved in it.

It was noted by Ministers and Ministry of Health officials that the development of the DHBs was also a continuation of Labour Party health policy during the 1980s: the DHB structure mirrored the Area Health Board (AHB) structure established during the 1980s, aimed at focusing on the health of the people living in a particular area, and not just on hospital services.

Some key informants felt that the main principle underlying the model was to be different from what was there before. There were perceptions, for example, that, under the previous model, contracting relationships were costly and bureaucratic; and that the RHAs had a large region to cover, while DHBs would be closer to their communities. There were also comments that one of the National Government's mistakes was to try to design a health care system from scratch.

The reforms were also in part seen to be a reaction to the competitive model introduced by the National government during the 1990s. One Minister spoke of the 'quasi-market' model as focused 'very strongly on a competitive company financial bottom line approach' (KII 2), and along with Ministerial advisors noted they did not believe a competitive model is constructive or efficient in delivering health, particularly in a small

country like New Zealand where competition is limited. Others also spoke of the model being at least in part a reaction to the competitive ethos of the 1990s. One Ministry of Health official noted however that one positive aspect of the 'quasi-market' was primary care providers moving from being a collection of independent, small providers to networked groups, providing umbrella organisations with which DHBs can work to promote health, and plan and deliver health care services across a continuum of care. This official suggested the ability for DHBs to work with primary care providers in this way could not have occurred in the days of the AHBs.

One official expressed concerns about whether the Labour proposals for reform would achieve the goals they were intended to achieve and whether these were the most important problems to be addressing at all.

Goals

A number of key informants noted the key goal of the reforms was to establish a sector-wide population focus for health. Taking a population health focus was not well defined, although a number of people identified that a key aim of the reforms was to encourage a shift of focus away from hospital services to primary and preventative care.

Some noted devolution and community participation as key ends in themselves, with the reforms aiming at changing the way the health system was governed, the way the decisions were taken and having people involved in those decision-making processes. One official felt there was a belief that outcomes could be improved by working more at a local level, but thought this was a leap of faith rather than a proven strategy.

Key informants also noted the government wished to open the health system up, 'warts and all' in the words of one Minister (KII 2). This would occur by allowing the media to attend meetings, allowing members of the public to sit in on meetings and to appear before the DHB, putting their views forward, i.e. the DHB model would operate with as

much information as possible. The aim was to make the system open and transparent. The comment was made that ‘the public actually can be quite sensible about what’s going on if they don’t think there’s a conspiracy that’s in secret’ (KII 2). This Minister felt that early impressions suggested the DHBs are doing much more business in public.

What Is It About Local That Is Important?

One key informant suggested that the local engagement with communities is about getting people to do things. That is, by locating decisions close to where they happen, things are more likely to happen and there is a higher chance the solutions found to problems will work. This was contrasted with a national approach which might be inappropriate for a local area.

Another suggested that the local focus is a cultural thing, where New Zealanders like to control their own lives, and where there is a resistance to policy and service developments being driven from Wellington. Others noted the importance of local communities having a voice in service planning and delivery, such that local accountability is really important. This would give greater confidence in the prioritization process that goes on locally.

However, some noted that although local input is important, having local elections to obtain local input was concerning, because those elected may not be competent to do the job, and local elections may not always see the best candidates being elected.

Building from Existing Structures

A fundamental aspect of the development of the DHB model and its implementation was a move from 22 Hospital and Health Services to 21 DHBs¹¹.

Views were mixed as to why there are 21 DHBs representing the districts they do:

- A desire to quickly move the health care system to focus on health matters rather than engaging in arguments over the number and location of DHBs. Thus the 21 DHBs were established around the existing organizations, that is, the HHSs, in part to reduce the potential political costs of the reforms.
- As a simple way of keeping the financial costs of implementing the new system down as far as possible. Thus, the existing hospital management role in HHSs was expanded, rather than establishing new organisations. Some noted that, from a policy perspective, there is a trade-off between economies of scale and the ability to manage within a budget, favouring larger DHBs, against the closeness of DHBs to a local population, favouring smaller DHBs. New Zealand's social geography is also important, with many geographical boundaries leading to natural communities of interest. One official noted 'in the absence of any compelling logic saying that a different number would be correct...., it's politically a sensible decision' (KII 12).
- A return to the previous model of hospital boards and AHBs based around hospitals, and a deep-seated view that hospitals are central to the health care system in New Zealand. Some reflected that DHBs are linked to hospitals, with a natural structure deriving from the number and location of hospitals. One official noted however that DHBs did not need to have a hospital. This derived from a view that 'the concept of the DHB is the community of interest that can focus on the health and disability needs of its population' (KII 14).

¹¹ The original 23 CHEs became 22 HHSs with the amalgamation of Whakatane and Tauranga CHEs into Pacific Health HHS in 1999; 22 HHSs then became 21 DHBs with the amalgamation of the two Christchurch HHSs into one DHB.

There was, however, also recognition from both Ministers and officials that 21 DHBs were probably more than would have been chosen if the system was being built from scratch. One official noted there was an inclination to have fewer DHBs, but this would lead to very large areas being covered by single DHBs, where there were different communities of interest and different health care needs (for example, in Auckland). It would also require a cumbersome ward structure to support board elections. Others noted that in addition to encouraging a smoother transition, establishing 21 DHBs and enabling voluntary amalgamations over time was a more sensible approach. Economies of scale could be encouraged through co-operation between DHBs (and such co-operation would be beneficial in itself).

Another issue that was canvassed during the reforms process was whether DHBs should have the same boundaries as regional councils, with seventeen DHBs. However, this option was discarded, although in the context of discussion anticipating mergers of DHBs over time.

Although the final policy settled on having 21 DHBs, some key informants expressed concerns over this. One suggested that 21 DHBs would be fine 'if the services they were running were much more limited and they didn't have this plethora of functions', and that 'as a conduit for very large sums of money, they're going to be incoherent, inconsistent' (KII 3). Another suggested that the 21 DHBs were there because they meet with the government's political objectives. It is making sure that it's got DHBs in areas that are politically sensitive to it' (KII 6). This key informant suggested that some DHBs are not viable because of their size, having to contract out or work with other DHBs in providing management support services as well as health services. Thus, they expected such DHBs to be absorbed into larger DHBs, with the governing Board becoming no more than a community committee.

Another key informant suggested that having 21 DHBs would lead to extra administrative and transaction costs, although they noted there would be 21 hospital managements anyway. They pointed to ways around this, by having DHBs willingly ‘adopt the national approaches to things’ (KII 10). Thus, they might implement things that everyone else is doing well, and ‘focus their energies on things that were more specific to their areas’ (KII 10).

3.2 Governance

Accountability

The mix of accountabilities is one of the most interesting and controversial features of the model. One official stressed that ‘district health boards are very, very clearly accountable to their Minister’ (KII 14), and similar views were repeated by Ministers and other officials, who pointed to the Act as clearly stipulating accountability to the Minister of Health. It was noted, ‘these are not local government boards...They are unashamedly there to implement the government of the day’s health strategy and they’re accountable [to central government] and that’s in the legislation’ (KII 2).

One Minister saw this as an essential part of New Zealand’s health care system, given that funding comes from the government and is setting up the NZ Health Strategy. A number of key informants made similar comments, noting that elected members represent the area on the Board, bringing local knowledge to the decision-making. One Minister suggested there is an awful lot DHBs can make up their own minds about, including how to deliver services, while another key informant commented that ‘we have to see New Zealand as one country not as a whole bunch of little fiefdoms and you cannot allocate resources and not replicate each others services...’ (KII 9).

One key informant noted the tensions, but did not see them as a significant problem: ‘Oh well I think whenever you have democracy you have a tension in accountability actually. It’s not a bad thing, I don’t think it’s something that’s going to be a particular problem’. They thought that most candidates would have been aware of these issues, but they stood because they were keen on ‘revitalising the public health system...’ (KII 16).

In contrast, some officials and opposition spokespeople saw the mix of accountabilities as a significant problem, seeing a real source of tension or friction within the health care system. One felt that if DHBs develop a life of their own they would come into conflict, with accountabilities to central government. Another felt the public would be confused by who to hold to account with Boards being accountable formally to the Minister rather than to the community who elected them. Yet another felt that some people elected to Boards might have made bold promises and now faced the reality of being accountable to the Ministry of Health. This meant the model brought opportunities for ‘martyrdom’, where Board members would be able to argue they are not funded adequately and they have to do what the Minister says. Others noted elected Board members may find it confusing to be directly accountable to the Minister of Health, rather than to the people who elected them.

Ministers acknowledged the potential for tension here, and that there was a need for further education on this issue.

Two others felt the structure is set up so the Minister of Health can pass on responsibility to DHBs and let them become ‘fall guys for drastic cuts’ (KII 3).

Several key informants noted tensions around who can speak on behalf of DHBs as an issue; some key informants suggested Board members are being ‘gagged’ when, for example, only Chairs may speak with the media. It was perceived this could be particularly problematic when members were seeking re-election as they would find it hard to point to examples of their impact on decision-making when they cannot speak out.

Another commented that the idea that the Minister of Health can just fire the Board members is wrong, given that DHBs are locally elected bodies.

Some key informants, both officials and Ministers, noted that this mix of accountabilities and the tensions it brings were reasons to have a different model. One official noted that the government was told that it would be making life difficult for itself by having strong local governance and strong upward accountability and no local funding of health care. However, the government was not going to even entertain the idea of thinking about how to make the local governors financially accountable in some respect, even if it was at the margin (for example as with the UK social services, where housing local authorities raise 40% of their funds), even if such local funding would lead to a more coherent set of accountabilities. Another key informant noted that they sought DHBs to be established as local councils are, but that this idea was rejected.

Key informants had different views of the likely impact of the model on the clarity of accountability in New Zealand's health care system. One thought the model was a backward step, as the 'quasi-market' model had quite clear accountabilities (providers meet contractual obligations to purchaser RHAs/HFA; RHAs/HFA are accountable to the Minister of Health for delivery against funding agreements; the Minister of Health accountable for funding levels). Accountability through elected representatives was considered by this key informant to be a poor substitute: '...a very shallow way of looking at it because it says you elect somebody and they'll be accountable and if you don't like them you can throw them out again. Whereas the accountability of a government and taxpayer's needs in health are around efficient use of taxpayers' money...and those things I think are being lost in the system' (KII 6).

Another key informant raised a further concern around the accountability arrangements. If DHBs did not have a reasonable scope of budget and responsibility for a reasonable range of service, then it would be impossible to hold them to account for anything. They would simply be able to argue that what they were doing was influenced by a whole range of constraints. This key informant noted that if New Zealand was going this far to develop a devolved model, then we should go the whole hog and devolve [total] responsibility to DHBs.

Role of Statutory Committees

The idea for Statutory Committees for each DHB appears to have come from a decision that hospitals would be owned by the DHBs. It was therefore suggested a hospital advisory committee be established to maintain a separate focus on the proper management of hospital assets. The DHB governing Board would focus on population health, with an advisory committee to manage hospital assets. In order to have a degree of symmetry, it was suggested (by Ministers) that ‘equal and opposite’ committees were needed to focus on other issues, although some officials felt this was the task of the DHB Board. It was also decided these committees would be statutory committees, rather than leaving it up to each DHB to decide whether or not to have them.

One key informant noted the establishment of a Community and Public Health Advisory Committee (CPHAC) allowed a way of involving health professionals who were not hospital employees in the work of the DHB. This was viewed as important, and a number of key informants noted the importance of the CPHAC committee having a population health focus, particularly given the concerns expressed by many that hospitals would dominate DHBs’ attention, development and funding. Some key informants expressed delight in having a CPHAC, given New Zealand should be trying to prevent people from becoming sick. Another noted having an elected Board did not guarantee local responsiveness and DHBs could engage with their populations in part through the statutory committees. Thus, the committees provided another way of bringing more people into Boards’ functioning.

Others felt the various committees were ‘sops to...vested interests’ (KII 7), and to be about ‘political correctness’ (KII 6). One official questioned whether having such committees would provide the means by which we would have effective and ‘quick-moving’ DHBs.

One key informant noted that originally DHBs could have devolved funding decision-making to the statutory committees, with not even a Board member on the committee. This was seen by some as ‘back-door privatisation’, with concerns that such committees would have a significant degree of commercial pressure put on them. Board members now can/should sit on these committees.

The role of the Disability Advisory Committees (DSACs) was particularly unclear in the early days of the model. Confusion surrounded their roles given the disability support services’ funding had not been devolved to DHBs¹². It was noted that some DHBs had raised queries about the role of DSACs. The Government saw the committees as having a role in ensuring the general health care services provided by DHBs (in their role as service providers) would be responsive and accessible to people with disabilities. The government wrote to DHBs to inform them of this.

¹² Funding for services for the over 65s is to be devolved from 1 October 2003.

Role of Communities/Transparency

One of the main differences between the model and the 'quasi-market' models of the 1990s relates to the role of local communities in decision-making. All key informants pointed to the importance of this to the new model. This was expressed in various ways:

- 'Responsiveness to the community' (KII 14).
- 'What you're trying to create is an environment locally whereby...relationships will be established, consultation can occur and the public can have confidence in the local decision-making' (KII 14).
- 'The good thing is the community has to face the pain...The community has to sit around the table and help to [ration]' (KII 15).
- 'I don't have any doubt that the community wanted to have an elected voice.' (KII 3).

Key informants pointed to a range of mechanisms within the model designed to achieve a greater role for communities:

- 'Holding meetings in public, liaising with the community about expectations, consulting on strategic plans...' (KII 14).
- 'Consultation has always been a big part of the model, including for needs assessment processes, major service reconfiguration requirements being developed' (KII 13).

Some key informants noted the differences with earlier models, ie that ‘...holding meetings in public, liaising with the community about expectations, consulting on strategic plans – these were not the responsibility of CHEs or HHSs. Their task was to do what was in their contract with the Minister’ (KII 14). One official noted that the local offices of the HFA were engaged in local contracting; that they had quite a lot of local information and understanding, but that their relations with local communities were relatively shallowly rooted (KII 11).

One official was uncertain whether research evidence shows wide consultation makes a big difference, although another commented there is evidence from AHB days of the effectiveness of consultation in making a difference.

3.3 Strategic Decision-Making

Needs Assessment and Prioritisation

A number of key informants stressed that within the legislation, the New Zealand Health Strategy was to provide the strategic direction and framework for the whole sector.

Health needs assessments (HNAs) were also required under the Act, because it was seen as silly ‘to run a health system without actually checking up and getting documentary evidence of what the needs are...it was important that communities should do proper in-depth surveys...but now under the Act all communities are required to take that initiative and it’s a very good tool’ (KII 1). Some officials thought the inclusion of such a requirement in legislation – stating what an entity ought to do – is unusual, particularly as it is then important to define what an HNA actually is.

One key informant commented: ‘I think it will be quite useful as a...communication mechanism with the population...If they do have to make difficult decisions, it will give them a point of reference...’ (KII 12). This key informant also felt that DHB HNAs would be ‘more local’ than the RHA (or HFA) needs assessments had been.

A number of key informants also noted the importance of the health needs assessments (HNAs) as a major driver of the prioritisation process in DHBs. The New Zealand Health Strategy gives the high level strategic areas, and the tool kits give practical advice on how to actually achieve health gain. The HNAs were then intended to be: ‘...the local information that actually complemented what was in the tool kits in the New Zealand Health Strategy...the HNAs were intended to come up with a response to those 13 areas and ...say how important those 13 were in the local DHBs so that...the DHB could run them by saying that diabetes really isn’t a big issue for us here but cancer is so we’re going to put resources there. And in addition it could also come up with new areas...that the NZHS hadn’t mentioned...The HNA...intended to give the evidence base for DHBs to be able to...turn around to the Ministry of Health and say well we’re going to concentrate on this area because we’ve got evidence that’s what’s happening...’ (KII 13). Thus, the HNAs were seen to give the DHBs flexibility to meet local needs.

Other informants noted the importance of the HNAs to the strategic planning processes that DHBs must undertake. That is, the DHBs ‘...take the needs assessment, put that together with resourcing, availability, currency and capacity to move things on the edges and then work through a strategic planning process with their local communities and then come back to the Minister for sign off on this is where we want to go in the next three to five years (KII 14).

Key informant officials hoped the DHBs would be given the freedom to use the results of the HNAs once they became more mature. One expressed concerns there may be inconsistencies between the preferences of local populations and central government strategies and regulations, such as the service coverage requirements, and that this might place constraints on DHBs’ ability to do what they want to do locally.

Others highlighted the important linkage between HNA and prioritization. They noted the goal of meeting needs leads to a need to do HNA and then to have to prioritise, given that there is limited funding available to meet those needs.

Another official suggested potential problems with HNA; that they would result in the collection of a lot of data, coming up with the same information already known about. This official noted, for example, that we know there are difficult things to deal with, such as how to get primary care for some groups that are disadvantaged health wise. This key informant saw the real problems resting in finding ways to get people to prioritise, to make choices and to identify how we make the most impact with the needs areas we know about. Others speculated that the HNA would look at quite narrow indicators.

3.4 Implementation of Key Strategies

A number of key informants noted that Strategies play an important role in the reformed health care sector. The NZHS is viewed by Government as signalling a change from a 1990s focus on disease management towards more of a preventative approach, where population health goals and then service priority objectives are set out, accompanied by a strategic approach to achieving them. The NZDS was seen as essential to the New Zealand health care system, and it was noted people with disabilities do not believe they are sick, nor are they part of the health system but they might need health services. *He Korowai Oranga/The Māori Health Strategy* is very much based on the NZHS, and is designed to build forward: ‘...so that we don’t suddenly say, stop all that good work you’re doing and start here. It’s been very carefully structured to accommodate the previous focus and yet to take us into the future’ (KII 14). It builds on Māori provider development and mainstream responsiveness and is connected to *The Primary Health Care Strategy* which ‘...is designed to get outreach and capitation and to be a tool for the DHBs to actually reach the hard-to-reach’ (KII 14).

The Labour-Alliance Primary Health Care Strategy developed out of a National government policy. However, a number of key informants noted that it was rewritten and is substantially different from the National Party policy, as the Labour-Alliance government ‘...didn’t approve of the direction; it continued to be a highly competitive model. It was based on an American approach to health care.... It wasn’t on co-operation between health professionals. It was very much around doctors. It didn’t have a community involvement in it. It didn’t have a not-for-profit focus...’ (KII 2). The Labour-Alliance government also ‘...made it clear that primary health care is a team approach. There are more to primary health care than just one health professional group although doctors are obviously the cornerstone of primary health care’ (KII 2). Finally, the government also wanted affordable and accessible primary health care, which meant changing the way primary health care is funded. The government, however, wanted that additional funding to go towards more holistic primary care, and not simply towards groups of GPs. PHOs therefore must have a much broader concept of primary care. This approach was criticised by one key informant who noted that organisations, on which PHOs are seen to be based, ‘...are a tiny part of the whole and somehow have seemed to create the idea that they’re the blueprint...’ (KII 3).

3.5 Devolution

A number of key informants noted one of the paradoxes of the model is that the government is establishing 21 local decision-making bodies (DHBs) at the same time as talking about national consistency. Officials spoke of devolving decision-making (over time), but always noted this would be ‘within nationwide frameworks’, taking account of national strategies and priorities, and service coverage frameworks, all of which are seen to seek national consistency of access and reductions in inequalities. Those interviewed felt the model would tend to exacerbate tensions between local, regional and national decision-making processes and priorities, and decision-making would probably be dominated by national priorities. One official suggested this would happen in part because of the size, expertise and experience of the Ministry of Health.

Although it was noted by some key informants that the legislation was written with devolution in mind, a number indicated services were to be devolved as and when the DHBs were ready. A number of reasons were given for this:

- One key informant noted there were some issues about a highly devolved system that were troublesome; the policy ought not to be seen as devolving funding decisions, but as devolving accountability, advice, planning, and monitoring to the Boards, but ‘actually central government should not evade responsibility’ (KII 3).
- Another rationale related to national services: ‘...we had a policy of tertiary services being funded or organised nationally. By definition that’s what they are. They’re not local issues, they’re national issues’ (KII 3). As well, some contracts held nationally might never be devolved because it could result in dividing a very small contractor amongst 21 DHBs and fragmenting it.
- Others noted the decision to phase in devolution was based in part on the readiness of DHBs to accept the work.
- Further, ‘there was a very definite decision to retain public health in the meantime because we believe there needs to be a national focus on public health. There needs to be regional planning of it and local delivery....Public health issues are ones that will need to have a nationwide focus...’ (KII 2). Mental health services, it was decided, might be better managed regionally.
- According to one key informant, this phased approach was also aimed at ensuring DHBs were not set up to fail. Thus, the approach was to ensure that the provision of care and money going into health is protected.

Some officials saw these as pragmatic decisions, which also recognised some services were already centrally funded by the HFA; leaving the central or national funding in place would mean the structure was not going backwards, but was building forwards. Others saw the decisions in a different way; noting there had been a ‘vigorous’ (KII 11) debate between and within agencies about which services were appropriate to be managed at local level. Some were concerned DHBs ought not to be responsible for all services at any time, while others were concerned DHBs ought not have all the responsibility at the beginning of the process. One key informant noted there was a lot of opposition from national providers who said it would be costly if responsibility for funding, contracting and monitoring services went to DHBs. The providers stressed that government had come into power saying it wanted to reduce the complex transactions of the market.

Some officials were concerned about the implications for accountability if a DHB did not have a reasonable scope of budget and range of services, as it would be impossible to hold them to account for anything. However, one informant also noted the most convincing concern was whether DHBs would have the critical mass of staff and expertise to cope with the range of tasks they were to be given. Also raised was a concern that ‘...the risk...was that once the purchase role for certain services became vested in the Ministry of Health it would be very, very hard to shift it, for understandable reasons, particularly if it was going okay’ (KII 11).

3.6 NZPHDA Model Overall

Performance

Key informants had a number of different views about the likely performance of the NZPHDA model overall:

- Some suggested the health care system would simply continue to improve at the rate it did previously.
- Others were concerned about the cost of the restructuring itself, and about the costs associated with the ‘Eye-off-the-ball problem of restructuring’ (KII 11), where there is a loss of focus on key issues while the structure is being reformed.
- Some suggested the system would only work as well as the level of funding provided to it would allow, and that the reforms would not alter the need for funding to be increased.
- Yet another noted the need for an emphasis on primary health rather than hospital care, if the system were to work well.
- One felt that elected members came with agendas, eg staff member projects, or being committed to a small rural area. In their past experience of the AHB model ‘...you didn’t actually see what you’d think of as a community voice representing lots of people. You saw people who were passionate enough to put up with local body politics, to get themselves on the board and wheel their wheelbarrow around the boardroom at every meeting’ (KII 8).
- Another key informant suggested problems would arise with decisions on what services to buy or provide now being taken by an organisation that provides some of those services itself.

- One key informant noted the reforms did not seem to be having any impact on work in the hospital ('not one iota' according to those they had spoken to (KII 5)) although they acknowledged the reforms may have an impact in time.
- Finally, yet another key informant wondered what impact structural organisational and government reforms ever have on health of any group in the population.

Key informants made a number of suggestions about how the health care system in New Zealand ought to be structured. A number suggested purchasing authorities should be separated out from hospitals. These key informants suggested we have either a number of separate purchasing agencies (maybe eight or ten), or only one purchasing agency (given our size), or we link purchasing and provision at the primary care level, as with the development of Primary Care Groups and Trusts in the United Kingdom. Another key informant suggested we should not over-burden government with regulation, licensing, monitoring and evaluation, and that possibly, informing people better [about their] entitlement to care was perhaps a better option.

In response to questions seeking comparisons between the NZPHDA model and other models of health care system organisation, key informants noted a number of issues:

- One commented that the idea of having a Board responsible for the health of a geographical population was implemented through AHBs, but didn't work because the old hospital boards were very parochial and resistant to change.

- Yet another suggested that going from four funders to one was a backward step because it distanced the funder from their communities. They felt the RHAs had been heading in the right direction, but the 1993 reforms could have retained elected Boards for the RHAs, and this would have been a positive thing in contrast with elected Boards under AHBs running the hospitals. They also noted the previous model was not successful with continuity/integration of care, with the CHEs seeing everything in episodic terms.
- Another informant expressed concern that the strong focus AHBs had on hospitals would return under the NZPHDA model because of a potential lack of will to shift resources. They also pointed to the excellent community development that took place under the 'quasi-market' model where small organisations grew in capability and confidence. This included Maori organisations being involved in planning, decision-making, monitoring and evaluation. However, some saw this as undermining the integrity of the public health system.
- Two key informants lamented the potential loss of tools the RHAs and HFA had developed to assist in managing the system. They suggested the pricing models developed during the 1990s provided transparency in a system that would essentially always be a bilateral monopoly or a system requiring regulation because the government purchases and supplies most services. These key informants also felt it was sad that contracting was no longer considered a good thing; and that the private sector could not access resources. They also raised concerns that the technical capability of the HFA would be lost with devolution.

- Similarly, these key informants felt the strength of the HFA included its national perspective; nothing short of the HFA could have grappled with the problems the RHAs and CHEs had to address. It had required focus, power and direct political connection. The weaknesses of the HFA were the usual capability ones but it was given a very sophisticated task to perform. It worked well getting people to think nationally and did good work with national Maori health policies. But they also recognized it was too visible, too big, and lacked political support. ‘When the pressure came on the politicians that created it stood aside and didn’t defend it’ (KII 8).

Challenges

Key informants noted the following as key challenges in the reformed health care sector:

- Funding: a number commented that the hardest thing for DHBs will be to live within their budgets. There would be continuing pressure on funding, and DHB Board members may find it difficult to deal with competing pressures and complexities in deciding what to do with their funding, for example, balancing the needs of staff with those of patients. One key informant suggested the major challenge to DHBs will be sufficient funding to do what they are being asked to do.
- Pulling away from hospitals: again, a number commented that a particular challenge would be between hospital funding and funding for preventative health care, as well as changing people’s understanding of health generally.
- An evolutionary strategy: one key informant raised a concern that the more evolutionary the changes, the slower cultural change required in the sector will occur, that is, towards collaboration and cooperation.

One key informant pointed to potential downsides for nationwide consistency, noting that ‘...trying to get a DHB to do something within an overall health strategy is not as easy as one might think’ (KII 16).

- Taking the budget constraint seriously: Some key informants were concerned that DHBs might not take the budget constraint seriously and may not make the necessary changes to service delivery.
- Defensible processes: One key informant suggested DHBs need defensible processes, even if people disagree with their decisions.
- Dual accountability of DHBs to government. Some key informants felt this could be rectified by making it clear what the role of a DHB is.
- Size of DHBs: One key informant noted DHBs are operating with small budgets which would make it difficult to manage risk. Another suggested some DHBs are not viable because of size.

Five Years’ Time

Key informants were also asked about what they thought the health care system would look like in five years time. There were very different views on this.

Some were very positive, one suggesting ‘ideally what we will see is relatively autonomous, not totally autonomous DHBs working within strong nationwide frameworks and responsive to local need about how they go about their delivery’ (KII 14) and with ‘systems of care that are integrated from prevention of diabetes through to the treatment of secondary complications’ (KII 14).

Primary health care service developments were of particular importance for others, one noting that ‘we’ll see PHOs with a brief to keep people healthy and reach people and bring them in’ (KII 2). One key informant thought PHOs might be taking on more responsibility in five years time, taking some decisions away from DHBs (as with Primary Care Groups/Trusts in the UK). Another noted it is very important for PHOs to break the hold of hospitals on health care resources.

Some key informants were positive but more tempered in what they thought could be achieved in five years’ time. One suggested there would be ongoing patchy performance. They also suggested we would still not have full coverage of primary health care and affordable primary health care, although the areas of greatest need should have been covered by then. It was felt by then we would have had the second DHB election; a strong understanding of obligations and roles; some measurable improvements in some of the goals, eg immunization; and a whole lot more data collected through Working to Add Value through E-information (WAVE).

One key informant suggested how the system will look like in five years’ time will depend on who wins the next general elections. They envisage National splitting hospital ownership from the DHBs, having DHBs purely as funders and amalgamating some DHBs. Thus, hospital advisory committees would become hospital boards managing hospitals, on contract to DHB funders.

Others suggested there would need to have been changes by then, for example thinking about whether we have the right number of elected members on Boards, considering participation vs capacity; ‘you really want people who know what they are doing’ (KII 15). Several key informants suggested we would see amalgamations by then.

4 Findings: Implementation and Initial Experiences

Some key informants expressed doubts about changing the direction of the sector, given many of the people working in it had been working in a particular way for the last 10 years. There were also concerns that the Ministry of Health had been gutted as staff went to the RHAs and the HFA, and the sector had a very weak public health focus.

4.1 Governance

Elections and Appointment Processes

The election and appointment processes were important parts of implementing the model. Interim Boards were appointed prior to the election of boards in October 2001. In relation to the 2001 elections, key informants indicated they initially wondered if people would be interested in standing for DHBs. In the end, there was huge over-subscription, taken by a number of key informants to mean there is a lot of community interest in the DHBs, and that ‘the government was on to something... when it said that the keynote of reforms would be...local involvement and this move away from a technocratic approach ‘ (KII 11). One official noted that the turnout was pretty modest, but that the government should feel vindicated in establishing the model as a result of the numbers of people standing for election. Others felt it was ‘amazing’ that so many people wanted to take part, given the complex and difficult decisions DHB Board members have to make.

Ministers and officials noted problems in getting Māori and Pacific representation. Key informants felt a single transferable voting system would give better representation, but it wasn’t feasible at the time, and would have lead to two different systems for local elections in the same polling period, ‘tick on this one, rank on this one’ (KII 14).

Following the elections, Ministers and officials noted that an analysis of Board members was undertaken, identifying who was elected to Boards, what they brought to the Board, and what was missing from the Board in terms of the criteria and skills felt to be necessary. In some cases, more financial or business experience was needed, in others more clinical experience. The statutory requirements were also important in relation to Maori representation. Continuity, competence and leadership were also considered necessary on Boards. In one informant's view, finding the right chair, and deputy chair, is 'absolutely fundamental' to the success of the Board (KII 15).

One issue with the appointments process was that the team involved was stretched. The Minister consulted with colleagues and partners over these appointments, but according to some, the political processes were slow.

Others were less positive about the elections. They asked how the public could know who would be a good DHB Board member. One senior official spoke of not voting as it was impossible to judge how well candidates would perform. One informant, outside government, suggested there is a tendency to '...elect doctors because somehow or other people believe they'll be good in that role without any real evidence to support that' (KII 7).

Collective Responsibility

Following the election and appointment process, the issue of collective responsibility amongst DHB Board members arose. Collective responsibility would perhaps see DHB Board views represented to the public only by Chairs of Boards. Key informants had different views on this. Some recognized the difficulties that Chairs faced when members, as one stated, 'go off like loose cannons' (KII 9). On the other hand, this key informant noted a number of Board members have said they do not care that they are supposed to work through the chair in terms of public relations.

Another suggested that in a democracy, there is always this tension with accountability, and felt it is not a bad thing. This informant suggested that most candidates would have realized this would occur. At the same time, the visibility of the debate on collective responsibility may 'have created a bit of a suspicion we're hiding something' (KII 16). Others were extremely concerned about encouraging collective responsibility within the system. One key informant believes collective responsibility will break down over time, particularly during elections when elected members want to be able to have a stand on issues and show how well they represent their local communities.

Conflicts of Interest/Professionals on Boards

One key difference between the NZPHDA model and the 'quasi-market' model of the 1990s is that staff members working in DHBs are able to stand for election and/or be appointed to the DHB they work for. There were quite negative views on this expressed by some key informants. One suggested: 'The assumption historically it seems is that the public has had is that if somebody is in the health professions they know what they're talking about and can run a multi-million dollar board and be a good governor or a good director but that is absolutely ludicrous. Of course some...can do all of those things, but simply having a vested interest and know a little bit about it doesn't make them the right person for the role' (KII 9). Another suggested that we may see the professions with a bit more influence, either as Board members or in terms of influencing who gets elected and perhaps exerting influence on Board members once they've been elected. They worried naïve Board members might be more impressed, for example, when the director of medical services presents his report than when the chief financial officer does. Another suggested, as noted above, there is 'a real tendency to elect doctors because somehow or other people believe they'll be good in that role without any real evidence to support it' (KII 7).

Conflicts of interest in local governance are likely in a small country. One key informant noted that the legislation requires candidates to declare conflicts of interest, but this is not checked and no-one has the responsibility to ask someone not to stand because they have too many conflicts of interest. Rather, 'the onus is on the public to make the assessment and make sure people are as informed as possible in the voting' (KII 9). One suggestion is the media could have a role to play in checking such conflicts. One key informant suggested that other potential Board members could also play a role, but 'that's not a very constructive approach' (KII 9). It was felt that a number of people with significant conflicts of interest are on Boards, and a key issue is how workable it will be having people with business and professional interests/conflicts on the Boards. A crucial issue is how people make a distinction between their various responsibilities.

Training

It was noted in interviews that a training programme was held for new interim Board members and training for the post-election boards was modeled on it. For the post-election boards, the programme covered governance (run by experienced people from the Institute of Directors), and health. The latter day aimed at painting the big picture, so people understood what health is about, including that it is more than hospitals. It included Maori, Pacific and public health. It was noted it was quite difficult to fit it all into the allocated time, and to fit in with the availability of members and the time and cost involved with bringing people to Wellington. DHBs also ran briefings for their own members on local issues. It seemed elected people had their training session first. Appointed members were trained later. One key informant suggested it would be ideal if every Board member were to go on the five-day residential Institute of Directors course.

Board-Management Relationships

Under the model, Board members are no longer directors (as with companies), they are seen as stewards of the roles and responsibilities and the resources of the DHBs. A core issue is the distinction between governing and managing: the Boards are ‘not supposed to be managing the outputs. They’re supposed to [be] governing it...’ (KII 15). This did cause some initial problems, where some Board members had assumed they were going to manage rather than govern Boards. Even though the difference between governance and management had been conveyed to them, some Board members still saw their role as managing DHB organisations.

Performance Management

Key informants noted that performance in the health care sector is very difficult to manage. They saw the instruments available as being very blunt, especially as DHBs are never going to fall over or be unable to pay their staff. Key informants noted that informal mechanisms are more likely to be used in practice. These include monitoring and escalating monitoring where necessary, imposing additional reporting requirements and closer scrutiny of the DHBs. It was suggested that a good performance management framework needs to reward good people and good DHBs. It was also noted there was a risk that poor performance is rewarded, for example, by giving an organisation a big equity injection where there is a big deficit. It was noted that it is difficult for those organisations that have made the hard calls, and where they see other organisations not doing so, and yet getting rewarded with support.

Those we interviewed noted that some of the tools available to reward good performance include small things such as giving DHBs their payments at the beginning of the month so they benefit from the additional interest. Another approach is to group DHBs which perform well on a particular aspect with others not performing, to encourage cooperation and sharing of skills, knowledge and solutions. Another possibility suggested in interviews is to publish DHB performance data.

4.2 Strategic Decision-Making

Needs Assessment and Prioritisation

As noted above, key informants indicated that the NZHS was aimed at providing strategic direction and a framework for the whole of the health sector, and that it is mandated under the Act.

The details of developing the NZHS were discussed in our interviews. A sector reference group and an expert advisory group worked with the Ministry of Health to develop the NZHS. There were disagreements about the 13 population health priorities, with some involved seeking the inclusion of asthma from a Maori perspective, and violence, which was argued for very strongly. Twenty one meetings around the country with hui, fono and pilot focus group meetings were held to consult on the Strategy. Attendance at meetings was lower in the north than in the south. The biggest attendances were in Invercargill and Dunedin. In Auckland, only four or five people attended. This may have been due to apathy or over-consultation. ‘Overall I think all involved were surprised at how much buy-in we got and how little antagonism there was to it and how supportive people were’ (KII 13).

The NZHS sets out 13 priorities, which are deemed as having the most potential to improve health. The NZHS is supported by toolkits: ‘...you cannot have a high level strategy without something that translates into action for people, which is what the toolkits did’ (KII 13). The toolkits were originally intended to be updated on an annual basis, a task which was to be the responsibility of the individual directorates in the Ministry of Health.

The HNA process was intended as a key driver for the prioritisation process for the DHBs, to give them local information complementing what was in the NZHS and the toolkits. DHBs were expected to signal how they would respond to the 13 priority areas and to indicate how important these were in the local district. For example, diabetes is a key issue nationally but it may not be so for an individual DHB, where for example cancer might be a bigger issue. The HNA would provide the DHBs with information to help them make priority decisions and the flexibility to meet local needs. Local consultation would identify local issues not in the NZHS.

One key informant suggested the HNAs provided DHBs with a tool, a basis for decision-making and a way of indicating what was going on in their community as opposed to only having a sense of the issues resulting from the loudest voices and the squeakiest wheel. The HNAs generated a sense of satisfaction and were seen as a useful tool.

A large number of strategies or action plans now sit underneath the NZHS and NZDS. This raised the question as to which of the many priorities should Boards focus on. Some key informants noted that the Minister of Health has been very clear about seven 'start here' areas. They are congruent with the NZHS and the NZDS; 'so that's the starting point including for those who say there are forty strategies' (KII 14).

One key informant noted many of the 13 priority areas are public health areas and it may be difficult to hold DHBs to account for those areas if funding remains with the Ministry of Health.

Another key informant saw the strategies as a way in which the new government could make itself seem novel and distinctive. In this case, the strategies also allowed the government to shift the focus from outputs, activity, productivity and efficiency to quality, improving health, reducing disability and improving independence. The strategies are also an attempt to focus on health outcomes.

The Ministry of Health scrutinised DHB strategic and annual plans, to identify how the plans reflect the NZHS; particularly to see if they reflected wider messages about consultation, prioritisation and population health. The Ministry was also looking to see if there were signals indicating a mind-shift from a hospital to a population health perspective. One key informant noted some DHBs' plans showed this, but not all. Another noted the main challenge in implementing the NZHS is inadequate resources, even where there aren't financial problems, and that it is difficult to divert resources to population health issues such as obesity, nutrition and so on. Another noted that DHBs are grappling with rationing, rather than refusing to acknowledge the need to ration and screaming about under-funding.

4.3 Implementation of Key Strategies

NZ Disability Strategy

Ministers suggested that there was some nervousness around the development of the NZDS. They noted that some officials suggested the NZDS would raise expectations, and this was seen as a bad thing, as it would mean something would have to be done to meet those expectations; and done quickly. Yet the sector may not be able to deliver on it quickly. An alternative perspective was that raising expectations was a good idea: you raise them and then deliver on them, was how one Minister explained the rationale for the NZDS.

Comments were also made that officials were unhelpful and unresponsive at the beginning of the process, with a number of cabinet papers having to be rewritten at Ministerial level. It was noted that better progress was made with the establishment of a reference group, with Ministry of Health officials working closely with the members of the group, and officials learned about issues facing people with disabilities, and people with disabilities learned about how bureaucracies work.

Key informants saw the NZDS as having been well received and a very useful document. It was helpful that the disability community took ownership of the Strategy, and it was felt that people were using it as a framework against which service changes should be judged, and as a tool to encourage local agencies to implement it.

4.4 *Devolution*

Originally, Disability Support Service funding was to be devolved to the DHBs. However, some Ministers did not see this as their policy. The Ministry had concerns about the interface where people move from one service to another, or need more than one service at a time. Ministers, however, wished to have a better analysis about how much of the DSS budget is taken up by health care. For example, one Minister noted that residential care is part of the DSS budget, but suggested that this is not a health service, as it supports day-to-day living needs. Thus, decisions have now been taken to split the funding of Disability Support Services. Care for older people is being devolved to DHBs in October 2003; and decisions will then need to be made about who will fund services for people with sensory, intellectual and physical disabilities. In the meantime, the Ministry of Health continues to fund these and to work closely with DHBs.

4.5 *Adaptation of the Ministry of Health to New Role*

During the initial stages of policy development and implementation of the model, it was felt by Ministers that in the main, there was enthusiasm from officials for the new model. But concerns were expressed that there were difficulties with some officials, including some in the Ministry of Health, who were focused on having a competitive company financial bottom-line approach rather than a much more mainstream public sector approach. Over time, it was noted that the management team has changed and new directorates were established, reflecting government goals.

Some concerns were also expressed by Ministers that the Ministry of Health tended to be reactive rather than proactive: a desire was expressed for a proactive Ministry that picks up issues, helps generate ideas and discussion.

4.6 NZPHDA Model Overall

Performance

In terms of the performance of the Board members, Ministry of Health officials noted that they use organisation performance as a proxy for Board performance. ‘To be effective in the role, they have to know the organisation is doing what it ought to do as well as it can, and as effectively as it can, which means the organisation has to have systems that will tell them.... If they know that then they can tell the Minister, and that’s the kind of conversation we have with them’ (KII 15).

Working with other Boards

Officials we interviewed noted guidelines were given to DHBs during implementation, indicating that the government intended shared services agencies to be established, in order to promote efficiency, to protect the capacity of the HFA in technical areas (such as HNAs), and to make sure small DHBs that would otherwise not be able to obtain some skills, still had access to capacity for technical tasks. Key informants also noted there are a lot of ways in which DHBs can share activity, for example, in relation to shared financial systems, human resource systems, health care needs assessments or contract management. It was noted that early on in the reform process, the Ministry of Health asked DHBs how they would establish shared services agencies. The regional model grew out of the old HFA locality offices, giving the SSAs institutional memory.

One key informant suggested the SSAs would only be used during a transition period, as ‘a way of boards keeping the HFA staff doing some stuff. Increasingly boards are going to take over the role themselves and I think this shared service agency stuff will fall by the wayside’ (KII 6).

Appendix 3

Preliminary Analysis of Board Member Survey

1 Introduction

The purpose of the District Health Board (DHB) Board Member Questionnaire was to explore perceptions of the key goals and changes expected of the reforms; and general issues about the perceived roles of DHBs in decision making and in governance and accountability. The survey would allow us to see patterns in relation to governance, purchasing and accountability, across all DHBs, at a cheaper cost than interviewing members in all DHBs.

2 Methods

In June 2002, questionnaires were sent to all DHB Board members in 20 of the 21 DHBs (217 questionnaires in total). Reminders were sent out a month later. Sixty-six percent of questionnaires (n=144) were returned; a range of 45% to 82% across DHBs. Questions were asked in two ways; first using Likert scales, where respondents noted if they felt issues were not at all important (scored as 1) through to very important (5); or whether they strongly disagreed (scored as 1), disagreed (2), neither disagreed nor agreed (3), agreed (4) or strongly agreed (5) with statements relating to key issues; and, secondly, using questions where 'free text' responses were requested.

The Likert responses have been fully analysed, using SAS and SPSS, and are reported here. This statistical analysis was done by Dr Lou Gallagher. Data reported are the percent of total respondents, rather than the valid percent of respondents which would exclude missing data. Statistical significance was assessed using the 2 tailed t-test.

Differences between Board member groups are included here where there were significant differences between groups at the 5% level. Analysis of the ‘free text’ is not yet complete and will be included in a later report on the full analysis of the questionnaires. Lower case letters in brackets indicate the question number in the questionnaire.

3 Results

3.1 Characteristics of Board Members

This section provides demographic and other information on DHB Board members responding to our survey.

Sixty-five percent (n=97) of Board member respondents were elected, a further eleven (0.08%) were elected and appointed¹³, and nearly twenty-seven percent (n=40) of respondent members were appointed to Boards. Just under 70% of respondents became Board members following the October 2001 elections; just under 28% were members prior to the elections. 45% of appointed Board members were members prior to the 2001 elections compared with 15.6% of elected members; 78.6% of those who were members following the elections, were elected members. Of those elected to Boards, 91.8% (n=99) were non-Māori; 8.2% (n=9) were Māori. Of those respondents appointed to Boards, 37.5% (n=15) were Māori. Of the Maori respondents (including those who defined themselves as “Maori only” and also those who indicated “some” Maori ethnicity), 65.2% were appointed to Boards while 34.8% were elected. Of those elected to Boards, none were Samoan; of those appointed to Boards, 1 was Samoan. Similarly, of those elected to Boards, none were Cook Island Māori; of those appointed to Boards, 1 was Cook Island Māori.

¹³ Those both elected and appointed are likely to be Chairs of Board, elected by their communities and subsequently appointed Chair by the Minister of Health.

Nearly all Board members responding to the survey (94%) are members of a Board committee; just over half are members of a CPHAC; 38.9% are members of a DSAC and just under half are members of a HAC. Almost one-third of respondents are Chair of a Board Committee.

Very few (5.4%) of the respondent Board members are employees of the Board.

There are very few young people on Boards – 1.4% of those responding to the survey were aged 30 or under. Just over two-thirds of respondent Board members are aged 46-64. Almost fifty-four percent of respondent Board members are male; 45.6% are female. Of those women responding to the survey, 73.5% were elected to Boards. Of those men responding, 58.8% were elected to Boards. Of those respondents appointed to Boards, 35% were women while 65% were men.

Eighty-four percent of respondents belong to the European ethnic group. Eleven percent belong to a sole Māori group; fifteen percent indicate they belong to either a sole Māori only ethnic group or to the “Māori and another” ethnic group. Fewer than 1% of respondents belong to the Cook Island Māori group. Fewer than 1% of respondents belong to the Samoan group. Fewer than 1% belong to the Indian ethnic group. Three percent belong to only one “Other” group while seven percent belong to either the “Other” ethnic group or to the “Other and another” ethnic group.

Fifty-seven percent of respondents gave their main area of experience or expertise as community involvement; 55% as previous director or governance experience; forty-six percent as health professional; and 45% as business or commercial experience.

3.2 *Importance of Issues*

The DHB Board member survey asked respondents to:

- a) indicate how important they personally think a number of health and health service objectives are for the future of health and health services in their region
- b) indicate how much importance, at the time of the survey, is being given by their DHB to a number of health and health service objectives are for the future of health and health services in their region
- c) indicate the extent to which they expect progress will be made in their DHB over the next 2-3 years.

The health and health services issues set out in the survey were drawn from the Strategies and from the legislation governing the model.

The issues regarded as most important *personally to DHB Board members* were all rated quite highly (all scored means over 3.8 out of a scale of 5; all medians were 4 or 5)¹⁴.

The issues regarded as most important *personally to DHB Board members* were (as measured by a mean response of over 4.5):

- Improved health status in the community
- Quality health services
- Tackling high priority public health issues
- Reduced health inequalities and improved health status for all disadvantaged groups
- Independence and inclusion in society for people with disabilities, and
- Better access to services.

¹⁴ These data are yet to be analysed for statistical significance.

The issues regarded as having the least importance to *DHB members personally* (as measured by a mean response of under 4) were:

- Recognising the importance of the Treaty of Waitangi in health sector decision-making, and
- DHBs being environmentally responsible.

(Note: Involvement of the community in health sector decision-making had a mean score of just over 4, and, as with the above two objectives, was the only other objective to have a median score of 4 rather than 5).

With respect to perceived importance of issues *given by their DHB*, all objectives were scored quite highly (all scored means of over 3.4 out of a scale of 5; all except three objectives scored medians of four or over)

With respect to perceived importance of issues *given by their DHB*, the most important issues were (as measured by a mean score of 4 or more):

- Quality health services
- Improved health status in the community
- Reduced health inequalities and improved health status for Māori
- Recognising the importance of the Treaty of Waitangi in health sector decision-making, and
- Tackling high priority public health issues.

The least importance *given by their DHB*, were (as measured by a mean score of 3.5 or less):

- DHBs being environmentally responsible
- Reduced health inequalities and improved health status for Pacific peoples.

With respect to expected progress over the next two to three years, again all mean scores were relatively high, suggesting good progress is expected over the next two to three years (all means were over 3.2; all medians were 3 or 4).

Respondent DHB Board members noted the following where they expected significant progress (mean scores over 3.7):

- Tackling high priority public health issues
- Giving greater priority to primary care
- Recognising the importance of the Treaty of Waitangi in health sector decision-making.
- Integration of primary and secondary care services and
- Involvement of the community in health sector decision-making, and
- Quality health services.

Less progress was expected in relation to (mean score under 3.4):

- Reduced waiting times for services, and
- Reduced health inequalities and improved health status for Pacific peoples.

Women respondents were *more* likely to rate the following items as more important than men rated the same questions;

Personal importance attached to:

- Recognising the importance of the Treaty of Waitangi in health sector decision-making (p=0.046)
- Tackling high priority health issues (smoking, diabetes, etc.) (p=0.03)
- Reduced health inequalities and improved health status for all disadvantaged groups (p=0.001)
- Reduced health inequalities and improved health status for Māori (p=0.01)
- Reduced health inequalities and improved health status for Pacific peoples (p=0.01)

Progress potential attached to:

- Better access to services (p=0.02)
- Tackling high priority public health issues (p=0.04)
- Reduced waiting time for services (p=0.03)

Elected respondents were *more* likely to rate the following items as more important than non-elected respondents;

Personal importance attached to:

- Better access to services (p=0.01)
- Tackling high priority issues (p=0.03)

Elected respondents were *less* likely to rate the following item as more important:

The importance that the DHB is placing on;

- Better access to services (p=0.04).

Māori respondents were *more* likely to rate the following items as more important than non-Māori respondents:

Personal importance attached to:

- Recognise the importance of the Treaty of Waitangi in health sector decision-making (p=0.01)
- Reduced health inequalities and improved health status for all disadvantaged groups (p=0.01)
- Reduced health inequalities and improved health status for Māori (p=0.02)

The importance that the DHB is placing on;

- Increasing the confidence of the community in the health services (p=0.01)

Progress potential attached to:

- Integration of primary and secondary services (p=0.002)
- DHBs being good employers (p=0.02)
- DHBs being environmentally responsible (p=0.002)
- Better access to services (p=0.03)
- Reduced waiting times for services (p=0.01).

3.3 DHB Processes and Procedures

In Part 2 of the survey, we asked questions about DHB processes and procedures. Note that responses to some questions appear in relation to a number of our research themes. The survey question prompting this response is indicated by a letter in brackets after the result.

The Board Member Role

Just over a third of respondents agreed the Board has access to the right kind of information for decision-making; a further 16.1% strongly agreed, such that just over half were in agreement or strong agreement with the statement. One quarter of respondents neither agreed nor disagreed.(i) Women were less likely than men to agree with this statement (p=0.004).

There were mixed responses to the statement that the ‘real’ work and decision-making takes place outside formal Board or Committee meetings. 35.6% disagreed or strongly disagreed; 27.5% of respondents neither disagreed nor agreed; while just over a third agreed or strongly agreed. (k)

Almost 60% of respondents strongly agreed that they receive regular, adequate reports on financial performance; just under 30% agreed. Thus, most (87.3%) Board members agreed or strongly agreed that they receive regular, adequate reports on financial performance. (s)

78.5% of respondents agreed or strongly agreed that they receive regular, adequate reports on service performance. (t)

Accountability

Most respondents agreed that Government strategy plays an important part in Board decision-making (82.6% agreed or strongly agreed). (b)

There were mixed views on the statement that the Board sees its primary accountability to the government, not the local community. One-third of respondents neither agreed nor disagreed with the statement. 42.3% percent agreed or strongly agreed while 20.8% disagreed or strongly disagreed. (c)

One-third of respondents felt that the Board has an adequate level of autonomy; a further 16.1% strongly agreed. Thus, just under half agreed or strongly agreed that the Board has an adequate level of autonomy. 27.5% neither agreed nor disagreed, and just over 20% disagreed or strongly disagreed with the statement that the Board has an adequate level of autonomy. (u) Elected respondents were less likely to agree that the Board has an adequate level of autonomy ($p=0.03$); Māori respondents were more likely to agree ($p=0.04$).

Board Performance

44.3% of the those responding to the questionnaire agree that the Board is performing very effectively; a further 18.8% strongly agreed, Thus, just under two-thirds of members felt their Board is performing very effectively. 24.2% neither disagreed nor agreed while a very few disagreed or strongly disagreed. (zii)

Nearly two-thirds of respondents (65.8%) agreed or strongly agreed that the Board's main imperative is to remain within budget/minimize the deficit. 20.1% neither disagreed nor agreed and a further 13.4% disagreed or strongly disagreed. (g)

The Role of Statutory Committees

Just under three-quarters of respondents (73.2%) agreed or strongly agreed that Board Committees play a significant role in the work of the Board overall. (y)

Board Processes and Procedures

Just under a third of respondents agreed that there is normally adequate time for discussion of major issues; a further 16.8% strongly agreed. Thus, just under a half were in agreement or strong agreement that there is normally adequate time for discussion of major issues. One-quarter of respondents neither disagreed nor agreed; a further quarter strongly disagreed or disagreed. (j)

Just over 42% of respondents felt that Board meetings are run efficiently and well; a further 38.2% strongly agreed or agreed with the statement; thus, most Respondents (80.5%) feel that Board meetings are run efficiently and well.(i)

61.8% of respondents agreed or strongly agreed that there is discussion from time to time about the effectiveness of Board processes and procedures. 21.5% neither agreed nor disagreed (m)

There were mixed responses to the statement that Board discussion is dominated by hospital issues. Just under one third disagreed or strongly disagreed; 29.5% neither disagreed nor agreed; while a further 25.5% agreed and 13.4% strongly agreed that Board discussion is dominated by hospital issues (38.9% therefore agreed or strongly agreed). (o)

Almost half the respondents agreed that diverse points of view are valued in Board discussions; a further 28.9% strongly agreed. Thus, most respondents agreed or strongly agreed that diverse points of view are valued in Board discussions. (p)

73% of respondents agreed that conflicts of interest are well managed. (z)

44.3% of respondents responding to the questionnaire agree that the Board is performing very effectively; a further 18.8% strongly agreed. Thus, just under two-thirds of respondent members felt their Board is performing very effectively. 24.2% neither disagreed nor agreed while a very few (9.4%) disagreed or strongly disagreed. (zii)

Board-Management Relationships

68.5% of respondents agreed or strongly agreed that Board and management work well together. Only 12.1% disagreed or strongly disagreed.(f)

Just over half of the respondents strongly disagreed or disagreed that the Board is really a rubber stamp for management; just over a quarter agreed or strongly agreed with the statement. (h)

Just over one-third of respondents disagreed with the statement that the Board has had to become involved in ‘management’ issues sometimes; a further 9.4% strongly disagreed. A quarter of respondents responded differently, ie that sometimes the Board has had to become involved in ‘management’ issues; just over a quarter of respondents neither agreed nor disagreed. (n)

Just under forty percent of respondents agreed that Board and management share a common vision; a further 22.2% strongly agreed or almost strongly agreed, bringing the total proportion of members in agreement or strong agreement with the statement that Board and management share a common vision to 59.8%. Just over a quarter of respondents neither agreed nor disagreed that Board and management share a common vision. (w)

44.3% of respondents agreed or strongly agreed that their Board has a positive relationship with senior clinicians. However, 24.2% neither agreed nor disagreed while 23.5% disagreed that this was the case. (zi)

Strategic Decision-Making

Most respondents agreed that Government strategy plays an important part in Board decision-making (82.6% agreed or strongly agreed). (b)

There were mixed responses to the statement that Board discussion is dominated by hospital issues. Just under one third disagreed or strongly disagreed; 29.5% neither disagreed nor agreed; while a further 25.5% agreed and 13.4% strongly agreed that Board discussion is dominated by hospital issues (38.9% therefore agreed or strongly agreed). (o)

Many respondents (71.8%) agreed or strongly agree that the Board has established procedures for seeking community input. (q)

Almost half the respondents strongly agreed that the Board has established procedures for seeking input from whanau, hapu, iwi and Māori communities; a further one-third agreed. Thus, 83.3% of respondents agreed with the statement. (r) Māori were less likely to agree (p=0.02).

Almost a third of respondents neither agreed nor disagreed that the Board has effective ways of reporting to the community on its work; just over 37.6% agreed or strongly agreed that the Board has effective ways of reporting to the community on its work. Just under 30% disagreed or strongly disagreed that the Board has effective ways of reporting to the community on its work. Thus, there was a mixed response to the statement that the Board has effective ways of reporting to the community on its work. (v)

The Strategic Focus of Boards

Many respondents felt that their Board spends enough time on policy and strategic planning matters (with 59.8% responding agreement or strong agreement); some (14.1%) strongly disagreed or disagreed that sufficient time was spent on such issues. (a)

Most respondents agreed that Government strategy plays an important part in Board decision-making (82.6% agreed or strongly agreed). (b)

Almost 39% percent of respondents agreed that Board members bring special 'added-value' to decisions; a further 34.9% strongly agreed with this statement. (d)

Just over one-third of respondents agreed that the Board provides a clear vision for local health developments, a further 19.5% strongly agreed. (e)

Purchasing & Contracting

38.3% of respondents neither agreed nor disagreed that the Board is able to monitor service quality through provider contracts; 32.3% agreed or strongly agreed that the Board is able to monitor service quality through provider contracts. 20.8% of respondents disagreed or strongly disagreed the Board could do this task. (x)

NZPHDA Model

One-third of respondents felt that the Board has an adequate level of autonomy; a further 16.1% strongly agreed. Thus, just under half agreed or strongly agreed that the Board has an adequate level of autonomy. 27.5% neither agreed nor disagreed, and just over 20% disagreed or strongly disagreed with the statement that the Board has an adequate level of autonomy. (u) Elected respondents were less likely to agree that the Board has an adequate level of autonomy ($p=0.03$); Māori respondents were more likely to agree ($p=0.04$).

3.4 Personal Experience and Aspirations

Becoming a Board Member

There were also mixed views as to whether DHB Board members felt that prior to being appointed/elected, they felt adequately informed about relevant issues. 24.2% of respondents neither disagreed nor agreed; while 45% agreed or strongly agreed; and 29.6% disagreed or strongly disagreed. (j)

Nearly two-thirds of respondents agreed or strongly agreed that at this stage, they would probably choose to serve another term on the Board. 12.7% disagreed or strongly disagreed with the statement. (n)

28.9% of respondents neither disagreed nor agreed that they like more training for their role as a Board member. 40.9% agreed or strongly agreed; while 28.9% disagreed or strongly disagreed. (s)

The Board Member Role

Just over half of respondents strongly agreed that they have a clear understanding of their role as a Board member; a further 36.2% agreed. Thus, 87.2% of members agreed or strongly agreed that they have a clear understanding of their role as a Board member. (a) Elected respondents were less likely to agree that they had a clear understanding of their role ($p=0.007$).

Just under half of respondents agreed that they are able to influence Board decisions; a further 27.5% strongly agreed. Thus, just over three-quarters of members (75.2%) agreed or strongly agreed that they are able to influence Board decisions. (b) Elected respondents were less likely to agree that they were able to influence Board decisions ($p=.0006$).

Almost 60% of respondents strongly agree that they ask for more information if they need it; a further 35.6% agree, bringing to 93.3% the proportion of members agreeing or strongly agreeing that they ask for more information if they need it. (c)

Just under half the respondents responding to the questionnaire agreed that they have a good grasp of the issues facing the Board; just over a further third strongly agreed. Thus, most respondents (87.3%) agreed or strongly agreed that they have a good grasp of the issues facing the Board. (e)

Almost a third of respondents neither disagreed nor agreed that they find their workload as a Board member to be excessive. A slightly lower proportion (27.5%) disagreed, and a further 15.4% strongly disagreed, that they find their workload as a Board member to be excessive, bringing to 42.9% the proportion who disagreed or strongly disagreed. However, 25.5% agreed or strongly agreed that they find their workload to be excessive. (f)

Just under half of the respondents strongly agreed that they have a good personal relationship with their Board colleagues; a further 42.3% agreed or almost nearly strongly agreed. Thus, most respondents (87.9%) agreed or strongly agreed with this statement. Only 1.4% of respondents disagreed or strongly disagreed. (q)

Accountability

Almost a third of DHB respondents strongly agreed that a part of their role is in representing a local geographical area; with a further 22.1% agreeing, this meant that 53.6% of respondents had this view. However, 20.8% of respondents strongly disagreed; and a further 8.7% disagreed. (d) Elected respondents were more likely to agree that they see part of my role as representing a local geographical area ($p=0.02$).

There were mixed views about whether Board members saw part of their role as representing the interests of one or more special groups in the community. 25.5% strongly disagreed that this is a part of their role; a further 13.5% disagreed (or nearly disagreed), bringing to 39% the percentage who disagreed or strongly disagreed. However, 20.1% strongly agreed this is a part of their role, and a further 21.5% agreed, with 41.6% therefore agreeing or strongly agreeing. 16.8% neither disagreed nor agreed. (r) Māori respondents were more likely to see part of their role as representing the interests of one or more special groups in the community ($p=0.01$).

Just over a third of respondents strongly agreed that the Board is able to address important health issues; almost a further third agreed, bringing to 67.8% the percentage agreeing or strongly agreeing the Board is able to address important health issues. (o) Elected respondents were less likely to agree however that the Board is able to address important health issues ($p=0.003$).

Just over a third of respondents strongly agreed they feel there are times when Ministry and government interfere inappropriately in the work of the DHB; a further 26.2% agreed. Thus, 61.8% of respondents agreed or strongly agreed with this statement. (One person gave a score of 5.5.) 20.2% disagreed or strongly disagreed while 14.8% neither disagreed nor agreed. (g)

Just over one third of respondents agreed, and a further 15.4% strongly agreed they have a clear understanding of how their Board's performance is being assessed, bringing to 50.3% the proportion of respondents agreeing or strongly disagreeing with the statement. However, 27.5% neither disagreed nor agreed; while almost 20% of respondents disagreed or strongly disagreed. (h)

For those for whom the response was applicable (74.5% of respondents), almost one-third agreed that as an elected member, they feel able to handle the dual accountability to their community and the Minister of Health, and a further 23.6% strongly agreed. This meant a total of 55.4% of elected members felt able to handle this dual accountability. 24.5% neither disagreed nor agreed, while 20% disagreed or strongly disagreed they were able to handle the dual accountability. (k) Māori respondents were more likely to feel able to handle the dual accountability to their community and the Minister of Health ($p=0.005$).

For those for whom the response was applicable (43% of respondents; note this a higher proportion than indicated they were appointed; some elected members therefore answered the question), 58.4% agreed or strongly agreed that, as an appointed member, they feel principally accountable to the Minister of Health. 22.9% neither disagreed nor agreed, while 18.7% disagreed or strongly disagreed. (l)

For those for whom this question was applicable (29.5% of respondents), half disagreed or strongly disagreed that as a Māori Board member, their accountability to whanau/hapu/iwi is a source of personal tension for them. 19.2% neither disagreed nor agreed, while 30.7% agreed or strongly agreed. (m)

Board-Management Relationships

There were mixed views as to whether there are times when the Board needs to be involved in ‘management’ matters. Almost 30% of respondents disagreed with the statement; a further 16.1% strongly disagreed, bringing to 45.6% the proportion of members disagreeing or strongly disagreeing with the statement. 38.3% of respondents agreed or strongly agreed however with the statement. (i) Elected respondents were more likely to believe there are times when the Board needs to be involved in ‘management’ matters ($p=0.04$).

Adaptation of the Ministry of Health to New Role

Just over a third of respondents felt strongly that the Board needs more support from the Ministry and the government; a further 22.8% agreed, such that 59% agreed or strongly agreed with this statement. Just under 20% disagreed or strongly disagreed. (p)

Appendix 4

Preliminary Analysis of CEO Interviews

1 Introduction

As part of our research, we aim to interview DHB CEOs once per annum, on the themes focussed on in this research. This report provided a preliminary analysis of the first group of interviews.

2 Methods

Over approximately six months (late 2002 to early 2003) CEOs of five case study and thirteen non-case study DHBs (18) were interviewed, either in person or by phone. Interviews were transcribed, edited and then checked by the interviewee and corrected. This full interview review process has been completed for 13 transcripts, so this report represents only partial data. A preliminary review of the remaining transcripts suggests that data from these reflect similar trends.

3 CEOs' comments on Government's Expectations of the Reforms

3.1 Reform Goals

Most CEOs recognised the government's goals as being in two broad areas: a focus on health status and reducing inequalities via the New Zealand Health Strategy, and a system that allows community involvement and accountability through DHBs.

3.2 *Financial Expectations*

All CEOs acknowledged that the government's financial expectations were for DHBs to operate within budget and, where necessary, reduce deficits within three years. Several CEOs noted that the three-year funding pathway was helpful, but that there are cost drivers in the system beyond the control of DHBs that need attention nationally, for example, the cost of blood products, pharmaceuticals, wage pressures arising from labour market issues and pressures arising from changes in the exchange rate. Some CEOs noted that focus on deficits diverts attention from higher order health goals.

3.3 *Community Involvement*

All CEOs acknowledged the centrality of community involvement in the legislation, several noting the two 'streams' of involvement. The first, through the governance system of elected members and open meetings, was not seen as contributing as much to community involvement as the second stream, i.e., more structured processes many Boards had used as part of their strategic planning. One CEO referred to community involvement as 'a double-edged sword,' with both advantages and disadvantages.

3.4 *Primary Health Care Policy and PHOs*

More than half the CEOs commented on the government's expectations in terms of the desired outcomes of the policy (health status improvement, reorientation of health services, more efficient use of resources) and overall endorsed the merits of the policy. There were concerns among CEOs interviewed early on about the expectations of implementation ('the worst policy I've ever seen'; 'naive') and that this might be more difficult than anticipated. Some CEOs interviewed more recently expressed concern over the high level of Ministry control over the implementation process, which they attributed largely to concern over political risk.

3.5 Health Inequalities

All CEOs understood the priority attached by the government to addressing inequalities in health status. CEOs from areas where such inequalities are pronounced expressed extremely positive views about the potential for improvement; those from areas where there are fewer inequalities indicated that it would be difficult to demonstrate the gains.

4 CEO comments on DHB Governance

4.1 Board Meeting Dynamics

Overall CEOs reported that Board meeting processes and procedures were handled well and many paid strong tribute to their Chairs. CEOs with commercial experience acknowledged how difficult chairing a DHB is compared with chairing a commercial board.

Board meetings were organised in a variety of ways, with some smaller DHBs incorporating a 'community forum'. Most Boards also relied on informal workshops for members and staff to work together on issues, to allow team building and develop understandings of governance.

Some CEOs noted a division between elected and appointed members and the potential for the development of factions. Others reported that in their Boards there were no divisions and all members worked well and together.

4.2 Transparency of Meetings

CEOs acknowledged the importance of the spirit of the legislation to open Board meetings, and recognised both positive and negative aspects. Several indicated that public meetings definitely constrained the debate necessary for good decision-making, both in terms of the time available and frankness of discussion. Most Boards had devised mechanisms to overcome this, with informal workshops and making part of the Board meeting closed.

On the other hand, some CEOs noted the value of open meetings in managing community expectations, and being able to engage with the media in a more positive way. Taking the Board meeting to more remote areas was seen as another way of fulfilling the spirit of transparency.

4.3 Governance-Management Relationships

Most CEOs commented that there had been difficulties in maintaining proper boundaries between governance and management. This was felt to be because members had not clearly understood the governance role, but as time progressed there was much more clarity. About half of those commenting on this issue reported particular strategies for dealing with it: formal education of Boards, the chair working with members, a letter from the CEO or a chat with members.

Several CEOs viewed open communication as a good way of responding to or pre-empting boundary issues:

‘As they understand better, we can loosen up on the demarcation; I no longer feel the need to ask board members to approach me through the chair.’

‘We need to be flexible and not alienate the two [governance and management] from each other, each needs to have an understanding of the risks on both sides...a relationship, but at arms length.’

4.4 Board Members’ Knowledge and Skills

CEOs reported that elected members tended to be short of some of the technical skills, (particularly financial skill) and the depth of knowledge of the health system necessary to govern DHBs and challenge management effectively (‘I feel quite exposed’). On the other hand, the community knowledge and networks of elected members were highly valued. Overall CEOs were grateful for the presence of appointed members.

4.5 Strategic Leadership

Most CEOs reported that the level of strategic leadership demonstrated by Boards was relatively limited, with a need to raise the overall level of debate on issues. Several CEOs noted an over-reliance on management that they were concerned might lead to too narrow a focus and even resentment at management ‘dominance’.

Nearly all acknowledged that Boards had worked hard on their strategic plans under very difficult circumstances and time pressures. Boards were able to reach agreement and some members became involved in community consultation. The strong direction from government had meant that there were not many opportunities to demonstrate local leadership.

4.6 Accountability: Elected and Appointed Members

All CEOs indicated that elected members had a strong sense of accountability to the community, with many ‘struggling’ to see their primary accountability to the Minister. Elected members were more likely to be ‘loose cannons.’ CEOs reported that as time went on strategies for dealing with this had been developed: leadership from Chairs; being proactive about contentious issues; seeking to involve the Minister and Ministry; appointed members fully acknowledging the tension for elected colleagues. In instances where the CEO felt it had not been a major issue there were indications that this was due to: role of chair; appointed members recognising the dilemma for elected members and supporting them; high level of skill and competence in some elected members.

Some CEOs felt that this would be a persistent issue as elections came around. Some also noted that despite the variability of Board member backgrounds and skills, Board relationships were good, with good teamwork emerging.

4.7 Employees on the Board¹⁵

The CEOs who commented on this noted that there was definite potential for conflict of interest, and some difficulties were reported, with the need to have ‘some distance in the governance role.’ Whether problems emerged depended on the attitude of the member (‘the employee approached it very sensibly’ ‘it needed some training for them to recognise it’, or ‘it will always be a problem with X’). CEOs noted the importance of clarifying the roles and relationships, ‘In board meetings I treat them as my employer.’ Overall the presence of employees was regarded as a problem to be managed rather than a major issue with the legislation.

¹⁵ In the Board member survey, 5.4% of respondents indicated they are also DHB employees.

4.8 Board Performance

Most CEOs reported progress and improved performance of Boards overall, but also noted that major input had been required to achieve the levels attained (workshops, Board training, inputs of chairs acknowledged as significant). They also expressed concern about likely membership turnover at election time.

4.9 Statutory Committees

A strong majority of CEOs reported that the governance structure, with three mandatory committees, is excessive. The HAC was seen as filling an important role, but both DSAC and CPHAC (once the Strategic Plan was completed) were reported to have little meaningful work. The burden of committee maintenance was seen as costly compared with any benefits accrued ('waste of space', 'a soak for management time'). Of the few CEOs commenting favourably on the role of the subcommittees, one reported that the committees were useful for actively structuring community involvement, another commented on the value of having all issues fully discussed prior to a Board meeting.

5 CEO Comments on DHB-Ministry Relationships

Most CEOs reported that their relationship with the Ministry was either good or improving. They acknowledged the difficulties faced by the Ministry in implementing the reforms in a relatively short time period, and there was high regard for senior Ministry officials, some of whom had been very supportive of CEOs individually. However, there was also a strong perception of a reluctance to devolve on the part of the Ministry ('the empire strikes back') and too great an involvement in operational matters.

Several CEOs reported on excellent relationships with account managers, but a need for improved co-ordination, and reduction of ‘single issue desks’. There is an expectation that over time the Ministry and Boards will develop a more appropriate relationship based on their statutory roles and responsibilities.

6 CEO Comments on Strengths and Weaknesses of the New Structures

Overall CEOs saw more strengths than weaknesses. The major reported strength of the new arrangements is bringing funding together locally. The involvement of the community in planning and decision-making is seen as a strength, allowing both responsive services and the management of expectations. In terms of policy orientation, strengths are seen in the move away from a commercial towards a ‘social responsibility’ ethos. Co-operative approaches between DHBs benefit both large and small DHBs alike.

The major reported weaknesses of the new structure are the presence of elected members, higher than desirable levels of central control, and the transaction costs of a cumbersome governance structure and large number of DHBs.

However, most of the weaknesses were seen as manageable; irritations rather than features that seriously undermine the system. Major change was not recommended (‘just buff it up a bit’) and many CEOs anticipated improvements (eg. in relationships with the Ministry, involvement of elected members) over time.

Appendix 5

Case Study Preliminary Analyses

1 Introduction

In order to get more depth of information, five case study districts were selected for study in detail. These case studies are designed to allow closer examination of District Health DHB decision making, governance, purchasing and accountability, to understand how relationships develop with local communities and providers, and to explore how local communities and providers view the new model of health system organisation.

These five DHBs were chosen to be representative of DHBs with different characteristics. They serve small, medium and large populations, communities with different age and ethnic mixes and cover urban, rural and provincial communities. The financial situation of these case studies DHBs also differs.

The case study investigation focuses on six aspects of governance and decision making: DHB owned hospital services; DHB owned public health services; primary care; community mental health agencies; iwi and other providers; community care organisations. These cover the experiences of DHB owned services, community providers, plus some specific services where across DHB co-ordination is important. Investigating these areas allows assessment of the change from purchaser-provider separation to the integrated approach. It also provides the opportunity to document the different ways in which relationships are managed and the strengths and weaknesses of the model in action.

Data are being collected by document analysis, interview and Board meeting observation. Interviews gathering the case study data are being done in two rounds. The first round, carried out from August 2002 to March 2003, investigates the expectations and implementation of the model. The findings from the first set of interviews will be reported back to the case study DHBs late 2003 or early 2004, once this data has been fully analysed. The second round of interviews, to be carried out in 2004, will look at progress with the model.

This report represents information from all five case study DHBs. Not all points apply to all DHBs. Full analysis of the data from the first set of interviews has not been completed. Thus, the findings presented in this report are interim only and represent the key impressions gained by the researchers.

2 Methods

Information in this report has been gathered by interviewing key DHB Board members and staff, and providers and other stakeholders who regularly deal with the DHB. There has been very good co-operation from all five DHBs, demonstrated by reflective interviews with key staff and timely and ongoing provision of documents. The number of informants interviewed in each case study DHB by the time of this report ranged from 15 to 43. Three case study teams had no “declines,” the fourth had one informant who suggested an alternative informant instead, and on the fifth case study, one informant did not attend and was not pursued.

Where possible, interviews were face-to-face, but if this was not possible, interviews were conducted by telephone. Interview schedules were developed with the same schedule being used for the same, or similar, roles across the DHBs. Interviews were taped with the interviewee's permission, and tapes transcribed, checked and returned to interviewees to make any desired changes. Where interviews were not taped, notes were taken, written up and returned to interviewees for checking. Some data have been analysed by a process of thematic analysis using Nvivo. This process will be completed in early 2004.

3 Findings

3.1 Governance

Becoming a Board Member

It was noted in one DHB that when Boards are elected, the resulting mix of skills and capacities is 'a bit of an unknown' and can leave Boards with a poor mix of skills, expertise gaps and members with variable abilities and interests. The importance of government being able to fill these gaps with appointed members was stressed by case study informants in several DHBs. Case study informants in one DHB noted that elected members can improve the breadth of decision-making, by contributing a wide range of skill and expertise, eg people with health sector backgrounds are seen as helping decision-making (within the proper management of conflicts of interest). The prospect of good elected Board members being voted off the Board and consequent loss of competency, expertise and institutional knowledge was raised as a concern in one DHB; there was a perception in one DHB that elected members who are also staff can be a barrier to progress; and in another DHB it was felt that the Ministry should not have anything to do with appointing Board members.

The Board Member Role

One DHB reported a lack of governance experience. Some DHBs have found governance a difficult concept to understand and put into practice. Demarcation problems between DHB members and managers were reported in some DHBs with reports of Board members interfering at management level and managers not understanding the role of governance. In one DHB it was noted that the Board sometimes gets involved in operational issues; in several DHBs, it was suggested that governance/management roles should not be seen as divided by a 'clear line in the sand' and that a pragmatic approach is needed. In one DHB, the Chair is seen to be very clear on the distinction between governance and management and communicates this to the Board through governance seminars and the use of a handbook. In another, the governance role is seen as evolving, and there is still 'a way to go' to achieve effective governance, but signs are that the organisation is moving on and maturing in this area. In two DHBs, there have been joint Board member/management training in governance, and this was seen as positive.

Accountability

In one DHB, tensions are visible in the behaviour of elected members, some members finding their role difficult regarding where their allegiance lies, and to whom they are accountable. Dilemmas can arise when there is a conflict between advice from their constituents and other sources of advice. Similar comments were made in another DHB on the differences in the way different members consider issues at the Board table. In one DHB it was noted however that some appointed members also have 'constituencies'. Dual accountability is recognised as a reality in one DHB.

There are also dilemmas for elected members wanting to contribute but having to abide by collective accountability, and this is seen as possibly working against aspirations for election. Although there is an understanding and empathy for this position, it does not sit well with the requirements of the Act.

Performance Management

In three DHBs, it was felt that the amount of time spent on addressing performance monitoring is onerous and the amount of information requested too detailed, tying up DHB staff for far too long. In one DHB the comment was made that the dollars soaked up in this way could be used for 'core business' and also that the Ministry are 'intrusive in their control of DHB business' through performance monitoring.

The Strategic Focus of Boards

In one DHB there is a perception that business decisions may be less robust with elected members, as they tend to be 'clouded by more emotion' than when there is a totally appointed Board. Appointed Board members tended to ask 'what is good for the organisation', whereas there could be more emotion in decision-making with an elected Board. In another DHB, it was noted that some elected Board members tend to have a narrow focus on particular services rather than a broader strategic perspective.

Some non-DHB case study interviewees drew attention to the fact that, despite the rhetoric of the DHB's strategic plan, their current focus remains firmly on hospitals and the deficit, rather than on development of services and health outcomes.

The Role of Statutory Committees

Boards have adapted committee structures. Thus, for example, one Board has in effect combined the Community and Public Health Advisory Committee (CPHAC) and Hospital Advisory Committee (HAC). Both committees have the same membership and meetings are held on the same day. The original two committee chairs (both Board members) have been retained and chair role is split between these two people. The rationale given for this is that the provider arm should be treated the same way as other providers in terms of purchasing services if the DHB is to refocus from a hospital

orientation to a health DHB. The system seems to be working well though some outsiders were critical of the DHB's focus on (a) hospitals and (b) the deficit rather than on development of services and health outcomes.

Additional committees have also been established in Boards. These include finance and audit committees, site or facility development committees, human resources or remuneration committees, quality and risk management committees, and funding management committees. Finance or funding committees are perceived in one DHB as the most powerful of the committees as they consider all the resource implications of other committees' recommendations.

Disability Support Advisory Committees (DSACs) generally report being frustrated at being in a "hiatus" at present, with hope that it will become very useful once disability funding has been devolved. One DSAC has developed a DHB Disability Action Plan (in line with its responsibilities under the New Zealand Disability Strategy); others are keen to take up their tasks once funding for disability support services is devolved.

CPHAC at one DHB reported its main function had been in a governance role during the development of the strategic plan but that it has struggled with its role and the need to become community oriented. It was reported to us that the perception was that CPHACs around the country are struggling to become more community-oriented. In one DHB an opinion was expressed that CPHAC needs to 'step up to its next stage' in terms of actually overseeing and reviewing the DHB's expenditure and the budget planning and funding.

One CPHAC has combined with Māori interests and initiated special public forums. Another sometimes uses the committee time to conduct small group working sessions on specific strategic issues, with any public attendees being invited to participate.

HAC in one DHB is perceived as a significant and powerful committee, with monitoring control over a substantial part of the DHB's spend. Its work appears to be 'business as usual' continuing from the CHE model. It too in this DHB is slowly coming to terms with what their role is.

Several DHBs report that much of the debate and decision-making occurs at the committee level rather than at full Board meetings. However, informants also noted that it was important the committees not operate independently of the Board. One interviewee regarded committees to be strong advocacy agents but it was also noted that Boards sometimes failed to take the advice of the committees.

In one DHB it was reported that the committees need to get service users involved more. In another, it was noted that external appointments were used as a means of balancing out the skill mix on various committees.

The Statutory Committees are reported by almost all the case study DHBs to be very costly to support from an administrative and management perspective, to take a massive amount of time in support, and to be a complication to governance-management-operations boundaries. In one DHB the workload of CPHAC was linked with strategic planning processes requiring a significant amount of work and to some lack of clarity over the committee roles.

Capacity and Capability of Boards

The need for more financial/business expertise on Boards was expressed in several DHBs. Some elected Board members were seen to have a narrow focus on particular services rather than a broader strategic perspective. Several Boards noted that they use workshops as a means of increasing understanding of particular issues and developing strategic direction. In one DHB, it was felt that the Ministry training for Board members was good, but it would be more useful if it came from past experience, successful Board members.

Board Processes and Procedures

Observations of Board meetings in one district show that meetings are formally conducted with close adherence to standing orders. They appear to be a forum for high-level sign-off of strategies, financial direction etc, but there is a perception that substantial decision-making occurs elsewhere.

One DHB reported personality tensions, ‘bickering’ at meetings and Board members unhappy with decisions revisiting the issue at later meetings as difficulties. Workshops are used to try and resolve differences. Other DHBs reported that Board members are working well together. Numerous conflicts of interest were noted in one DHB, with guidelines developed in another to manage this.

Transparency

Although Board meetings are open, public attendance is very low in most areas. Those that attend are seen to frequently have a particular agenda item that is of concern to them. Some Boards invite participation in discussion, others allow the public only as observers. Committee meetings are also open to the public. Though Boards report trying to hold more business in public there are difficulties if Board members discuss confidential issues at public meetings. In one DHB it was reported that decision-making is slower than in committees because of public being present, where Board members feel the need to give reasoning for their points of view and to reiterate their values base. Boards continue to use 'public excluded' times at meetings.

Board Performance

In one DHB it was noted that there is a strong sense that the model is evolving over time. In another DHB it was noted it was too early to say if the reforms were 'working', but almost all those interviewed felt that the model built positively on the reforms of the past. Time was now needed to bed the reforms in and 'fine tune' where necessary. In another DHB it was felt that DHBs are still on a learning curve, and it is still too early to comment on performance.

3.2 Strategic Decision-Making

Needs Assessment, Priority Setting, Planning and Budgeting

Needs-assessment exercises were undertaken by all DHBs. These proved useful in the development of the strategic plans.

In one DHB, internal analysts also produced a lengthy report on the role of DHBs in prioritisation processes. The funding team of one DHB experimented with a principles-based scoring system and the priority-ranking of all contracts in order to advise the Board on options for managing a projected \$2m deficit in the funding arm. The process gave some useful indication about where dis-investment might occur (which is critical, given the need to reduce deficits). However reducing the level of service provision proved politically unacceptable and the Board was directed not to reduce particular services. The general conclusion was that, given (a) that DHBs have limited resources, (b) many prioritisation decisions are applicable to all DHBs, and (c) many prioritisation decisions are made at the national level (including decisions which relate only to local services), any further development of a prioritisation process should be undertaken at the national level.

Reported barriers to effective decision-making have been: unclear boundaries of responsibilities between the Ministry and the DHBs; inconsistent messages and requirements coming from the Ministry, such as the requirement to carry out prioritisation when health priorities have already been set in the national strategies; political interference; lack of resources (especially time and skills); and inadequate information, especially poor information on existing contracts. In one DHB it was acknowledged that the planning process was jumbled, through time pressures.

Case study informants indicated that prioritisation and planning were largely driven by Ministry requirements and directives. There was not much opportunity to demonstrate local leadership because of the priority objectives of national health strategies, service coverage specifications and deficit reduction requirements. Historical spending was also a determinant of spending. Therefore, the already committed spending left little space for marginal or discretionary spending. Another barrier to effective decision-making was the poor information on existing contracts.

Role of Communities

Community and consumer involvement is one of the top 10 objectives in the strategic plan of one DHB and it is clear that both the Board and senior management are making concerted efforts to achieve this objective. Community stakeholders see the DHB's efforts to consult with communities as genuine consultation, not just lip-service to a statutory requirement. However, some providers in this DHB see consultation more as one-sided, with the DHB simply sharing its plans with providers. Another DHB refers to 'engagement' with consumers rather than consultation and uses a variety of methods including working parties on service issues using paid community representatives. Some communities in this DHB area reported feeling over-consulted. This DHB was attempting to discuss more business in public, but noted some difficulties where for example Board members start discussing confidential business in an open meeting.

At one DHB respondents generally noted the exercises in community consultation have been worthwhile. However one Board Chair noted that the consultation process is 'all very well but in the end the Board has to make the final decisions and be accountable for them'.

As noted above, statutory committee meetings are open to the public. In one case study DHB, these meetings sometime attract significant numbers of people. Though DHB informants report trying to hold more business in public, there are difficulties if Board members discuss confidential issues at public meetings and, having the public present is said to slow down decision making processes. Boards continue to use ‘public excluded’ times at meetings.

Also as noted above, Board observations indicate that, although Board meetings are open, public attendance is very low in most areas, although in one case study DHB, few people attend Board meetings but CPHACs are quite popular. Those that attend frequently have a particular agenda item that is of concern to them. Some Boards invite participation in discussion, whereas other Boards allow the public only as observers.

3.3 *Implementation of Key Strategies*

In three DHBs, it was noted that government Strategies were seen as key drivers, giving real leadership and underpinning for the strategic and annual plans.

Primary Health Care Strategy

Some DHBs have been very proactive in assisting with the development of PHOs in their districts and several have a number of PHOs established in their area. One DHB reports faster than anticipated progress. In one DHB, the plan to have geographically-based PHOs has not received support from some primary care providers, as providers contend that many consumers do not access primary care services according to their geographic location.

Some DHB interviewees were critical of the slow progress of the Strategy and of inadequate funding. There were also comments from one DHB that more is needed in terms of the realities of implementation, with many promises and projections made whereas the value of the model is seen as unclear by some as is the long term sustainability of PHOs.

Informants identified a number of strengths with the Strategy. Community involvement in the development of PHOs is considered a strength of the Strategy in one DHB. Some mainstream non-government organisation providers are positive about the more social, less medical model for healthcare. Lower co-payments for Māori, Pacific and lower socio-economic patients and increased flexibility with capitated funding were identified strengths.

PHO development is seen in one DHB to have exacerbated capacity issues for some Māori, Pacific and low-income providers, especially since they were the first groups to set up as PHOs and had none of the advantages of learning from others experience. Information technology capacity was noted as a particular concern. In one DHB it was noted that information technology development falls on those providers least equipped to bear this; in another DHB, one informant also identified the need for standardisation of information technology between PHOs and DHBs.

In one DHB, concerns were raised that there is potential for the PHO structure to create another level of bureaucracy; with their role and interaction with the DHB seen to be potentially problematic. In the same DHB there was seen a potential mismatch in funding decisions taken by the DHB and those by the Ministry for PHOs.

3.4 Funding

In one DHB it was noted that balanced against strategic goals set by the DHB are the resource constraints the DHB must work with. Increased collaboration with other DHBs and greater inter-region service collaboration are seen as ways of getting around resource and funding constraints and still delivering services by a smaller DHB. In another DHB a comment was made that where there are high expectations, hump or transition funding is needed.

The population-based funding formula is seen as a huge challenge in some DHBs. In one there is a perception that the formula needs to be robust with local conditions and local implications being considered; in another it is seen as potentially restricting patient choice as the dollars no longer automatically follow the patients. In one DHB a concern was raised that the formula uses out-of-date population statistics resulting in under-funding for DHBs due to rapid population growth and a rapidly changing ethnic mix.

In one DHB it was noted that there is not enough money to meet government or public expectations. This means there is a need for fairly strong rationing decisions, which have to be politically driven

3.5 Purchasing and Contracting

Case study informants gave mixed accounts of the devolution of contracts. Some DHBs reported that most contracts were devolved 1st July, 2001, six months after the establishment of the DHB, though at least two of the DHBs had an extended period of time during which contracts were handed over in a step-wise manner. For the DHBs with delayed devolution there were complaints that they could not prepare for managing the contracts and there were long delays in getting access to copies of the contracts.

At least one case study has found the process of hand-over to be excessively slow, which meant the DHB did not have copies of contracts even when they were responsible for managing provider organisations.

Two case study DHBs reported problems due to contracts being incomplete. For example, they noted inaccurate funding figures, other inaccuracies, or and missing details. One case study DHB noted that the mental health contracts were generally tidier, compared to the personal health contracts. All of the case study DHBs identified the due diligence process of checking the contracts as their first priority. This meant checking the transfer: were all the contracts passed over, were the individual contracts complete with all variations and associated letters, and did the money devolved match the contract obligations.

All the case study DHBs spoke of rolling over the majority of contracts initially. This was because of the sheer numbers of contracts received all at once and DHBs felt they had a first priority to check contracts for completeness; that they needed take stock of what was working; and because the contract terms determined when review was possible. One case study DHB informant placed priority on minimising risks to the organisation. This key informant stated they put monitoring processes in place but then avoided making changes which may have disrupted the sector, while they worked out what worked.

Some case study informants in DHBs noted that the DHBs did not initially have the capacity or capability to manage contracts. In the previous model, contracting had been done by the HFA. Comments suggest DHB funder arms had to rapidly upskill to manage this new role: some staff still consider contracting difficult to manage. One key informant spoke of receiving the contracts when they were still in the process of appointing contract managers, so they relied heavily on the shared service agency to manage the contracts on their behalf. Another noted the DHB received contracts when they were still developing their strategic plans, which would have placed limits on their ability to review the contracts if they had attempted it at that stage.

Once contracts came up for renewal, some were rolled over whereas some were renegotiated. One DHB indicated its priority was deficit management, so that the primary concern was looking for contracts that could be terminated. However this same DHB did also attempt a ranking exercise with a number of contracts being ranked according to a set of principles, including impact on health outcomes. Other case study DHB key informants also spoke of considering the contracts against their overall strategy. How quickly an individual contract was reviewed depended on the magnitude and importance of the contract, the significance of the provider, and the likelihood of political repercussions.

DHBs and providers in several DHBs reported major problems with the devolution of contracts. For one DHB, there were reported long delays in getting access to copies of the contracts in the early days. Another noted some contracts were unfinished and out-of-date, with discrepancies. This latter DHB noted there was learning on both sides with the DHB becoming more assertive in subsequent waves of devolution in terms of what was acceptable. However, delays meant that DHBs could not prepare for managing the contracts.

Some DHBs just rolled over contracts with providers making few changes while they concentrated on other aspects of establishing the DHB. Renegotiation of these contracts with providers is just beginning to occur. Contracting is also a new task that ex-Hospital and Health Service staff did not have to do in the previous model when it was done by the Health Funding Authority. Comments suggest DHB funder arms had to rapidly upskill to manage this new role. Some staff still consider the contracting role to be difficult to manage.

Provider Issues and Perspectives

For providers, it has been noted in one DHB that disagreements between the DHBs as to who pays for some patients crossing DHB boundaries has resulted in delays in payments for providers.

In one DHB, the comment was made that accountability requirements set by some DHBs are seen as onerous by small providers. Some providers in another DHB are frustrated that contracts are not focusing adequately on outcomes and sometimes even require the purchase of specific inputs (eg a particular position such as a coordinator).

In one DHB it was noted that the dual roles DHBs have as providers and funders can create tensions for non-DHB providers. Thus, for example, if something happens with one of those relationships, there is potential to 'diminish' the other. In addition, this is especially a problem where services are provided – or can potentially be provided - by both a DHB and by non-DHB providers (such as long-term care for the elderly and maternity services). Some providers expressed concern that in such circumstances DHBs would naturally tend to give preference to the DHB provider arm

Some regional and national providers have to deal with multiple DHBs regarding contracts. In one DHB, there was a perception that national planning under the Health Funding Authority was easier; and it was suggested that obtaining consistency and cohesiveness of contracting across DHBs is potentially problematic. Staggered devolution has also created difficulties for some NGOs/providers that provide services across devolved and non-devolved funded areas as they have to manage both central and local contracts.

In one DHB, it was commented by NGOs that generally the smaller DHBs are more proactive in forming relationships with NGOs. Some have commented that organisations are still in competition with each other to some degree, for example in relation to nursing and Māori staff.

3.6 Pacific Peoples and Pacific Health

At one DHB, there is no Pacific representation at Board level which means Pacific issues are not dealt with. Providers working within this district preferred the DHB model because of more understanding of local needs but at the same time voiced feelings of marginalisation because they are told Pacific people are a priority but they cannot see how this is translated or implemented into policy. Another DHB reported positive relationships between the appointed Pacific Board member, Pacific staff in the DHB and good links into the community.

Issues needing to be addressed with regard to Pacific people include: the need to build a stronger Pacific provider base and the Crown concept of “Pacific People” being a single entity – in reality there are numerous ethnicities.

3.7 Devolution

Some of the comments made during interviews with case study informants reflected concerns about autonomy of DHBs, and hence devolution of both funding and decision-making. In one DHB it was noted that the amount of autonomy the sector has is debateable and the reality is it is still centrally dictated. One case study informant noted the DHB was going to ‘get the accountability delivering services, but we aren’t going to get the responsibility for making the changes because so much as been prescribed’. The following examples were given:

- In one DHB, the unwillingness of the Minister to sign off the annual plan caused tension, when the Board considered their plan both reasonable and feasible.
- There was a comment in one DHB that central government can still dictate what has to be done and it has to be paid for, eg fertility and surgical services.

- It was noted in one DHB that it is as yet unclear where the locus of decision-making lies. DHBs are charged with needs assessment and prioritisation and yet their funding decisions are constrained by national frameworks and (on occasions) interference in local decisions by the centre. It also appears that the Ministry has the discretionary health dollar (eg, for the meningococcal programme), and yet according to the model, it is the DHBs who should be making resource decisions.
- There were comments made about the slow pace of devolving disability support and mental health money; and this was seen that the Ministry was ‘hanging onto the funding’.
- In another DHB it was commented that the Ministry has intervened in contracting decisions. It was suggested that this set a precedent for the future and could be challenging if the DHB has to find the money itself.
- Ringfencing of funding is perceived in one DHB as a major constraint, and although it may be a pragmatic approach for a period of time, it is seen as being used too often and should not be there ‘in perpetuity’, for example in mental health.

As far as public health funding is concerned, there was recognition within at least one case study DHB that national funding and organisation is appropriate for some services (such as screening services) where consistency in practices and in reporting is essential if the service is to be effective.

3.8 Capacity and Capability

In one DHB it was noted that there is no national capability to provide training – many DHB personnel are still trying to come up to speed in terms of handling contracts, understanding what the national frameworks mean and how to translate these into contractual agreements. In the same DHB it was also commented upon that the current model has fragmented the critical mass of expertise that had been formed under the HFA (such as Maori, Pacific and public health expertise). DHBs therefore lack capacity for many of their assumed roles.

In one DHB it was noted that new skills were required in a short time frame particularly in the funding positions as this was a completely new area. Upskilling in contract management took time, and in part led to the rolling over of contracts during a capacity building period.

Some non-government organisation (NGO) providers have also expressed concern that there is no primary care expertise within the DHBs at the senior management level.

3.9 Adaptation of the Ministry of Health to New Role

Relationships between the Ministry and DHBs are seen as good in the case study DHBs, even if they are strained at times. In one DHB, good relationships were attributed to a politically astute chair and key management personnel who pre-empt potential problems and talk to key people in the Ministry. From this same DHB the comment was made that the Ministry has been supportive in tough times. In one DHB, the posting of guidelines for consultation by the Ministry on their website was seen as a positive initiative, bringing the history of what has been learned about health consultation and a help to translate it into the new environment. In another DHB a comment was made that the Ministry has a wonderful skill base and an overview of where the health gaps are. Relationships with account managers were seen as very good.

However, a range of negative comments were also made about the Ministry and its role. Comments include (and in general these come from a number of DHBs):

- There is insufficient time for responses and feedback from DHBs to Ministry on key documents; the Ministry needs to recognise that DHBs require timely information and faster turnaround of documents; and time is also needed to co-ordinate a DHB-wide response.
- There is slow turnaround by Ministry of DHB documents and plans particularly annual plans and strategic plans.
- There can be duplication, fragmentation and a lack of communication within the Ministry which means DHBs do not get consistent messages, are asked to duplicate work for different sections of the Ministry and do not have clear reporting responsibilities.
- At times there is insufficient consultation – directives are sent without prior consultation or notice.
- In one DHB, there is a perception that some policies from the Ministry lack consultation and are framed as ‘you shall do this’, for example the operating policy framework. In this same DHB it was commented that the Ministry needs to understand that each DHB has some different processes and procedures.

Overall, the Ministry is seen as too bureaucratic and prescriptive; focusing too much on operational issues and ‘micro-managing’. This is seen to stifle flexibility and innovation at a local level. In one DHB it was commented that the Ministry is sometimes too rigid in its interpretation of rules; more flexibility is needed if the system is to meet the needs of local providers. In another DHB it was commented that DHBs have the rhetoric to be self-managing but the Ministry is still involving itself at the management level. In one

DHB it was commented that the lack of trust between the DHB and the Ministry goes both ways, and is frustrating and demoralising.

Some of the comments reflected concerns about autonomy of DHBs (see Devolution, above). In one DHB it was noted that the amount of autonomy the sector has is debateable and the reality is it is still centrally dictated. Another case study informant noted the DHB was going to 'get the accountability delivering services, but we aren't going to get the responsibility for making the changes because so much as been prescribed'. A number of examples were given earlier, leading the DHB concerns around autonomy.

In two DHBs, the comment was made that central government priorities are not always the same as local priorities and can create tensions. Local innovations can sometimes be at odds with the need for national consistency. This same DHB commented that national standards should be set before devolution. It was commented that the Ministry can cut across and not fully understand the role of the DHB and the planning of services.

There is a perception that the Ministry has a large resource that has changed little; that it has not shifted from funding back to policy and not upgraded its skills to reflect this change (for example, in monitoring which is a huge skill set not focused on areas of need); and that it needs to rearrange itself but is not there yet. In one DHB the feeling was expressed that the Ministry is not downsizing and taking on new role, causing tension and conflict. In another DHB, the comment was made that the Ministry should downsize and focus on strategic direction.

In one DHB it was commented that DHBs look to the Ministry for strong leadership, a co-ordinated approach, strong policy development but not interference in implementation. One comment was made that Ministry staff need experience outside the policy field; it is suggested that it would be helpful for Ministry policy staff to have experience working at the implementation and DHB level.

In one DHB it was suggested that workforce planning and development, particularly for Maori, needs national rather than local attention. In another, the comment was made that DHBs are 'all working in a bit of a vacuum', a need articulated to advertise successes around the country to understand what works, particularly in the area of integration.

3.10 NZPHDA Model

Working With Other DHBs

It was noted in one DHB that the large urban areas present some special issues and require regular inter-DHB consultation. Neighbouring urban and regional DHBs are working through the issues and relationships are improving. It was reported from this DHB that overall the development of the shared services agency seems to be going well, though its resources are limited. Some services have formed strong links with other DHBs.

In another DHB it was noted that collaboration and relationships with other DHBs are improving, but that further collaboration was needed. Two other DHBs also noted that a range of matters were being worked on jointly with other DHBs, for example, public health, human resources, information systems and on clinical matters. One noted there needs to be a willingness to contribute.

4 Overall Comments

There is general support for the DHB model. The following strengths of the model were identified, the first five mentioned frequently:

- The ability to look regionally at the needs of the population. Even with some constraints it is considered a ‘big advantage’ to have total funding for primary and secondary care, and across the continuum of care, and to be able to broaden the focus to include public health and population health concepts, away from ‘bottom of the cliff’ approaches with the CHE model.
- The ability to involve community in decision-making.
- The opportunity to be more locally responsive; in particular for the opportunity for better local planning and better local relationships.
- The ability to plan more effectively for the local population.
- Enhanced engagement with providers at the local level.
- Focus on inequalities, although a comment was made that the government has been negligent in trying to explain this to people.
- The increased focus on primary health care, and
- Increased transparency (eg clinical priorities with national waiting list model and finances) promotes more honest public expectations.

In one DHB it was noted that there is a strong sense that the model is evolving over time. It was also suggested that historical factors continue to exert a powerful role in the model. These arise in funding priorities and philosophy, although overall there appears a genuine desire to move to the more local DHB approach.

In one DHB the reforms are beginning to some extent to influence the culture of the institution eg improvement noted in devolution of responsibility to clinical areas.

In another DHB it was noted it was too early to say if the reforms were ‘working’, but almost all those interviewed felt that the model built positively on the reforms of the past. Time was now needed to bed the reforms in and ‘fine tune’ where necessary. In another DHB it was felt that DHBs are still on a learning curve, and it is still too early to comment on performance. In one DHB, several respondents commented the sector needs ‘no more paradigm shifts’; rather, what is needed is incremental developments.

Some weaknesses with the model were also noted; these have been discussed above throughout this report. Concerning the model overall however, frequent comments were made in most DHBs suggested that there are too many DHBs, too much duplication of effort and too many boundaries. Amalgamations/rationalisation are seen as almost inevitable. In one DHB it was noted that services could be planned in an ad hoc way and possible duplication could occur with each DHB doing own thing. Thus, regional ownership and collaboration were seen as important.

Appendix 6

Preliminary Analyses on Implementation of *The Primary Health Care Strategy*

1 Introduction

On 11 December 2000 Cabinet agreed to a strategy aimed at “improving the health of New Zealanders and reducing health inequalities through a strong primary care system.” (King, 2002). In February 2001 *The Primary Health Care Strategy* (PHCS) was introduced to create “an overall framework for the organisation and delivery of primary health care”, and thus provide direction to District Health Boards (DHBs) regarding the provision of primary health care services to their populations (King, 2001a).

2 Methods

Over approximately six months (late 2002 to early 2003) 15 people directly involved with primary care were interviewed, either in person or by phone. Semi-structured interview schedules were developed. Interviews were transcribed, edited and then checked by the interviewee and corrected. Where interviews were not transcribed, notes were taken, written up and returned to interviewees for checking. Data were analysed by a process of thematic analysis. All transcripts were entered into an NVivo database. These findings are based on preliminary analysis of the coded data.

Information for the investigation of the primary health care strategy was gained from three sources – publicly available official documentation, analysis of articles published in the related print media (primarily articles from *NZ Doctor* and *GP Weekly*), and interviews with key Ministry officials and sector stakeholders.

3 Findings

The PHCS is focused on reaching those not currently well served by primary care, extending primary care provision into population health, and changing modes of service provision. There is general agreement within the sector with the principles of the PHCS. But there was some dissatisfaction with many aspects of the consultation process, both in the development of the Strategy and in the implementation plan, and doubt as to the effectiveness of any feedback. This was manifested in comments from a variety of sector representatives that while the opportunity to communicate with the Ministry was good, there was a “lack of interest [from the Ministry] in hearing what was said”. There was also a sense the Ministry was “disconnected” from the sector with little understanding of the pressures, resulting in “the development of inadequate implementation policy.”

3.1 Implementation

Many in the sector, had concerns regarding the implementation of the PHCS. They expressed frustration with the lack of details particularly with regard to PHOs, and there was a desire for more explicit guidance in the transitional period.

Uncertainty generally prevails within the sector with regard to the make up and impact of PHOs, and there is concern as to whether sufficient money will be available to fully realise the vision of low cost health care for all, even in the long term.

Issues of equity are also anticipated during the transition period, and concerns regarding the proposed funding model for PHOs led to the development of an alternative funding formula by the Independent Practitioner Association Council (IPAC). Additionally, there are fears about the safeguarding of certain facets of general practice such as co-payments and the right to charge patient fees.

The move to the PHO system is seen as having potential for greater integration of services. It is however recognised that different types of PHOs around the country are likely to be set up very differently with different systems and processes around service provision. All health professionals are positive about the potential for better teamwork and innovative service provision allowed for in the PHO model. General practitioners however, have expressed concerns about the potential for a more demanding workload owing to a greater concentration of high-needs patients, combined with nurses taking over more routine activities, thus resulting in a need for increased “supervision, mentoring, time out and ongoing education”.

3.2 Costs

Comments have also been made regarding the “huge commitment of resources and energy” required for setting up a PHO, and annoyance expressed about getting swamped by information- and reporting-demands ‘because someone in a theoretical tower somewhere has decided that it would be a good idea to find out stuff’. Providers also fear a loss of their identity and that a “kind of bureaucratic overlay” will be placed on PHOs which “will get in the road of getting on with the work”.

3.3 Professional Workforce Issues

During the initial phase of PHCS implementation, delays in developing documents detailing the specifics of the implementation process exacerbated the prevailing sense of uncertainty, and fuelled disparate viewpoints within the sector regarding the impact of the reforms. It was noted that by and large health professionals at the front lines get on very well with each other. But fears about perceived threats to certain facets of practice led to professional organisations arguing for their own particular perspective or area of health concern. Many of the groups were perceived to be ‘operating on the basis of closing down any threat to themselves and maximising any opportunity’.

3.4 Other Issues

Amongst the issues identified by different groups within the primary health care sector are:

- The emphasis on primary health care as opposed to primary care, is seen as a recognition that general practice, while an important part of primary health care provision, does not define all primary health care services. The PHCS therefore is seen as providing greater opportunities and potentially an expanded role, particularly within nursing.

Tensions therefore exist within the sector over the relative roles of various providers/health professionals, and the balance between valuing existing services and introducing new ones. Mainstream general practitioners have expressed concerns the emphasis of the PHCS appears to be on alternatives to traditional practice. Sector commentators argue new modes of service delivery are being privileged, with little recognition being paid to the strengths of general practice.

Allied health professionals also are concerned that despite the wider view of primary health care expressed in the PHCS, this recognition does not extend beyond nursing, and innovative funding does not encompass allied health professionals.

- Nurses and allied health professionals have concerns about general practitioner dominance in the sector both at a governance/ funding/ structural level, and at a practical level (for example the continuation of the gatekeeper role with regard to referrals). There was also concern doctor groups would lobby for IPAs to make superficial changes to their governance structures and transform into PHOs, thus defeating the goals of the establishment of PHOs.

Allied health professionals not included in the minimum requirements for PHOs fear the possibility of a loss of autonomy particularly if GPs retain a strong gatekeeping role within a PHO.

3.5 Co-payments

Issues regarding co-payments remained contentious for a long time but have recently been resolved. However tensions still exist over the roll-out of the funding. As the uncertainties of implementing the PHCS are gradually resolved, strained relationships between professional groups in the sector are becoming more cordial, and to date 34 PHOs have been established.

Appendix 7

Summary on Disability Support Services

1 Introduction

The New Zealand Disability Strategy (NZDS), “Making a world of difference: Whakanui Oranga” was released in 2001. As part of our research, we have studied the implementation of the NZDS. This report briefly summarises the position of the strategy, and the responsibility for it, and looks at the role of the DHBs in relation to disability support services (DSS). This report was prepared with the help of Margaret Cochrane.

2 Methods

Over approximately six months (late 2002 to early 2003) seven people directly involved with the development and implementation planning of the NZDS were interviewed face-to-face. Interviews were transcribed, edited and then checked by the interviewee and corrected. The case study interviews have also included questions about the NZDS and DSS.

3 Summary

The Disability Issues Directorate in the Ministry of Health had responsibility for developing the NZDS. However the Ministry no longer has responsibility for disability issues; this role was transferred to the Office of Disability Issues within the Ministry of Social Development, from September 2002. Their work on disability issues is intersectoral, and involves the implementing and monitoring progress on the NZDS.

DHBs have a responsibility for delivering on the NZDS as a provider of services and as an employer. Because the NZDS is a whole-of-government approach, DHBs are required to demonstrate, as are all Government departments, they are providing services that reflect the Strategy. Therefore the DHBs have an obligation to provide services that are accessible to people with disabilities. Also DHBs have a duty as an employer to make sure they comply with the NZDS.

Funding for DSS was not devolved to DHBs with personal and mental health funding in 2001. Currently the Ministry of Health contracts with providers of disability support services. DHBs do provide some disability support services but these are very small for example Assessment, Transfer and Rehabilitation, wheelchairs and child development services. Most disability support services are provided by community providers, for example the IHC or CCS.

The decision against devolution of DSS funding arose from nervousness of both providers and consumers in the disability sector, as to whether DHBs were the appropriate place for funding to sit. This was based partly on a concern that DHB deficits would swallow up DSS funding. As well as this, there was concern about 21 different approaches and that DHBs were not the right place for disability support services funding since disability issues, particularly in younger people, are often not health related.

The decision was made to split disability service funding into two based on age, according to whether consumers are under 65 or 65 and over. This decision was made because of the differing needs of these groups. The needs of the majority of people with disabilities who are 65 and over are health related, whereas younger people, who tend to have lifelong disabilities, have needs which are much broader than health alone.

Funding for older people's DSS (65s and over) will be devolved to DHBs on 1 October 2003, subject to DHBs proving themselves capable. DHB capability is to be judged according to *The Health of Older People Strategy* (Dyson, 2002) which requires them to provide an integrated continuum of care. DHBs must also show that they have risk management plans to ensure DHB clients as a whole will not be adversely affected by the devolution and that they will take a nationwide approach to contracting residential care services for elderly people.

Funding for younger people's services will remain the responsibility of the Ministry of Health until at least 2004 when the Ministry will report to Cabinet on where funding should go. Younger people's funding is not being devolved with older people's funding because of a concern in the sector that DHBs, with their health focus, are not the appropriate place for disability funding.

Even though DSS funding has not been devolved, DHBs are required by statute to have a Disability Support Advisory Committee (DSAC). Even without funding, the Minister for Disability Issues sees these committees as having a role providing advice to their DHB on the health needs of their disabled population. This Minister and the Ministry of Health have both made efforts to educate DHB chairs about the role of the Disability Support Advisory Committee (DSAC). According to informants, in practice the DSACs are operating quite differently in different DHBs, ranging from those who regard the DSAC to have a minimal role until funding is devolved, to those who saw their DSAC as having a lobbying role.

Some providers deliver services for both younger people and for those 65 and over. In this case, providers will need separate contracts, with the Ministry of Health and also with the DHB in their area, for the services they provide to younger people and for the services they provide to those aged 65 and over respectively. Furthermore, some providers deliver services that span several areas, or DHB areas. Providers are also concerned about the potential for inconsistency across 21 DHBs. Further issues arise as people move from one age category into the other.

DHBs have concerns that they are taking on an under-funded service. Funding for older people is largely made up of residential care or rest homes. Residential care is demand driven. With the ageing population, DHBs are concerned that demand will increase to an unmanageable level. The work of 'Ageing in Place' means that people will be supported to stay at home longer which may alleviate some of the increase in demand for residential care.

There are potential workforce problems for DHBs. The Disability Services Directorate will devolve some staff with the devolution of funding. However, there are more DHBs than staff members to be devolved.

Appendix 8

Preliminary Analysis on Health Needs Assessments and Prioritisation

1 Introduction

The Minister of Health and the Minister responsible for disability issues are responsible under the Act for the over-arching New Zealand Health Strategy (NZHS) and New Zealand Disability Strategy (NZDS) to provide the framework for the Government's overall health sector direction in improving the health of people and communities and for disability support services (s. 8). The Health Needs Assessments (HNAs) are to be used to inform District Strategic Plans (DSPs) (s. 38). Community consultation on the draft DSP is mandatory under the Act (s.38, (3c)). The DSP states the objectives of the DHB for the 5 to 10 year period from the time of determination, and are to be made publicly available, as are any amendments. These plans are to be reviewed at least once every three years.

One of the early tasks then required of the newly formed DHBs was to carry out Health Needs Assessments (HNAs). Health needs assessment, which in this definition includes prioritisation, is defined as 'the assessment of the population's capacity to benefit from healthcare services, prioritised according to effectiveness, including cost-effectiveness, and funded within available resource' (Coster 2000).

2 Methods

A piece of research on DHB HNAs, priority setting and planning processes has been undertaken by Gregor Coster, who was a member of the Research Team until February 2003. The research is based on an analysis of DHB HNA and prioritisation documentation and semi-structured interviews with the DHB Planning and Funding Managers, undertaken in mid-2002. The research aimed to gain information regarding the process of HNA and prioritisation and to assess how well HNAs, prioritisation, DSPs, DAPs and budgeting were connected. This assessment was undertaken in interviews with questions to Planning and Funding Managers about how well strong they felt the connections were. Further assessment, using a detailed analysis of DHB documentation, is still to be undertaken.

The material below sets out some of the interim findings from this work, based on a preliminary analysis and write-up of results. Triangulation of the two main sources of data (document analysis and interviews with Funding and Planning Managers) was undertaken for these analyses.

3 Findings

3.1 *Health Needs Assessments*

- In general the DHB HNAs met the minimum requirements of the Ministry. There was however considerable variation in scope and quality of HNAs in DHBs.
- Twelve DHBs used the same consultants and produced similarly formatted plans. The processes established for these HNAs was seen as useful, although smaller DHBs found undertaking some parts of the process difficult because of limited local capacity. DHBs doing their own HNAs felt a greater sense of ‘ownership’ of the data and process.

- The degree of engagement with and participation by Māori varied considerably, from no consultation with Māori groups to full consultation. In some cases, Māori staff involvement was considered sufficient to obtain the Māori perspective. Some DHBs had difficulties with participation and engagement of Māori because the relationship with iwi was not in place and took time to establish. In retrospect, a number of DHBs stated they would have preferred to engage with Māori ‘earlier and better’.
- Community consultation during the HNAs varied considerably, perhaps due to differences in philosophical approach and resource availability. Those consulting with community and community health providers obtained valuable information from the process.
- Almost without exception, DHBs found difficulty in obtaining and validating data. Data most difficult to obtain were those from primary care (sometimes because IPAs and GPs would not release data) and mental health services (especially community data). Every DHB also commented on the poor quality of ethnicity data, especially for community-based services.
- Most DHBs found the time frames for completion of the HNAs tight. Most found the workload huge, putting on additional personnel to resource the project, in order to meet Ministry of Health deadlines. The costs of undertaking the HNAs, as estimated by DHBs, ranged from \$30,000 to \$300,000 with a mean of around \$75,000.

- Most DHBs found the process and outcomes of the HNAs a valuable exercise, although some DHBs commented that the HNA did not highlight a single issue that they did not know before. HNAs were seen to provide a solid base of information on which to plan health service delivery, and gave a great deal of information on which to plan health service delivery. Almost every DHB saw the HNA as a means of reviewing progress of the DHB, and planned to track changes in health status of the population over time. Some used data to develop performance indicators in order to measure progress against health targets to those proposed by the Ministry of Health.

3.2 Prioritisation

- The approach to prioritisation by DHBs varied considerably, particularly in regard to the amount of involvement of the local community. Most DHBs based their prioritisation frameworks on the HFA model, modified to allow for recognition of the 13 population health objectives.
- Funding management committees held the real power for decision-making in a number of DHBs. These consist of the CEO, a small number of key managers and sometimes the Chair, and they determine the final shape of annual plans. Minutes are not in the public domain, if they are taken. Recommendations from these committees were then sent to Boards for ratification.
- Government Strategies, particularly the NZHS, were a powerful force for all DHBs in the prioritisation process. DHBs found they could not find sufficient resources to address all 13 population health objectives, and they prioritised from that list.

- DHBs received service level requirements from the Ministry of Health, setting out the Ministry's expectations regarding levels of health service provision. Some DHBs endeavoured to manage deficits downwards by reducing access to services and were promptly told this could not be done.
- Almost all DHBs saw prioritisation applying to new money, and all stated that over 99% of their budgets were pre-determined by existing contracts with health providers. Some DHBs undertook a line-by-line approach to budget review, seeking to identify non-performing contracts and those where economies of scale could be achieved by amalgamating contracts that were duplication services.
- In terms of being able to allocate resources based on local needs and values, DHBs commented that contracts had long lead times to completion (eg with contracts having three year terms), and they were generally not prepared to terminate contracts prematurely unless there were performance issues.

3.3 Planning

- Key influences on DSPs were: legislation, Ministry guidelines, historical factors, HNAs, community feedback regarding preferences; and the financial constraints of the funding environment, including DHB deficits. Government Strategies and the 13 priority population objectives strongly determined the direction of DSPs, which required sign off by the Ministry. DHBs received strong messages that the Government's priority objectives had to be reflected in DSPs, and it appears that this was an overwhelming influence on decision-making.

3.4 Connections Between Health Needs Assessments and Purchasing

- There was good connection between priorities established by DHBs and HNAs for the majority of DHBs. A number of DHBs prepared their DAPs with little reference to DSPs, as in many cases the DSPs were written in parallel or subsequently to DAPs.
- Characteristics of DHBs with strong connections between HNA, priorities, DSP, DAP and budgeting were; timing; planning processes; stakeholder involvement (often in service planning groups, including community); and planning team expertise. Size was not related to success in the process; nor was size of deficit as a proportion of total budget.

Appendix 9

Summary on Shared Services Agencies

1 Introduction

The *New Zealand Public Health and Disability Act 2000* enabled the newly created District Health Boards (DHBs) to “actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities” [NZPHD Act 2000 Part 3 s23(b)].

As a result four shared services agencies (SSAs) were established:

- The Northern DHB Support Agency (NDSA) – servicing Auckland, Waitemata, Counties Manukau and Northland DHBs.
- HealthShare – servicing Bay of Plenty, Lakes, Tairāwhiti, Taranaki, and Waikato DHBs.
- The Central Region Technical Advisory Service (TAS) – servicing Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawkes Bay DHBs.
- The South Island Shared Services Agency (SISSAL) – servicing Nelson-Marlborough, Canterbury, West Coast, South Canterbury, Otago and Southland DHBs.

These agencies, owned by DHBs and accountable to DHBs, have a common purpose, to: support the activities of the owner DHBs by providing health service, planning and funding information, analysis and undertaking contract management and provider and stakeholder relationship tasks as determined by the DHBs.

The SSAs range in size from 11 (TAS) to 18 (SISSAL) full-time equivalent staff and from \$1.26 million (HealthShare) to \$1.88 million (NDSA) budgets. SSAs are governed by boards comprising shareholding DHB CEOs.

The purpose of this research is to investigate the rationale for, and the working of these agencies. This report was prepared by Siân French.

2 Methods

Over approximately six months (late 2002 to early 2003) five people working in Shared Service Agencies were interviewed, either in person or by phone. Structured interview schedules were used. Interviews were transcribed, edited and then checked by the interviewee and corrected.

3 Findings

The SSAs:

- Provide critical mass – of particular importance to smaller DHBs (large DHBs having a greater likelihood of a larger in-house funding and planning team).
- Provide DHBs with assistance for anything from small operational questions to input into significant service development projects.
- Helped retain continuity, capability and knowledge during the reforms process by providing opportunities for staff with expertise to remain within the health system. They were also contact points for providers during the change period.

- Take advantage of economies of scale – SSAs are specialised centres of expertise which undertake health planning and funding activities that are expensive and/or difficult to undertake in each DHB.
- Provide regional solutions – in health there are a number of services, projects and issues that are best advanced by regional coordination. SSAs facilitate the linking of DHB activities.

SSAs have been active in:

- Personal health – SSA teams generally undertake administration and management of generic contracts and some community based services. Service areas include general practice, oral health, pharmacies, community laboratories and private specialists.
- Mental health – tasks include: development and management of tendering and provider selection processes, refinement and implementation of regional mental health plans and maintenance of local and regional stakeholder networks.
- Provider quality audit – contract monitoring.

SSAs have developed ‘specialist’ areas of work for which they are recognised (particularly by sister SSAs). These include a research and applied analysis focus (TAS), service and relationship management (NDSA), change management (SISSAL), and auditing (HealthShare).

SSAs do not:

- Act as funders of health services.
- Develop direct relationships with providers or engage in service discussions unless directed to by the DHBs.
- Undertake community consultation.

SSAs have relationships with:

- DHBs – engagement is on a day-to-day basis, particularly with the General Managers, Planning and Funding.
- Providers – managing relationships with providers with, and on the behalf of, DHBs.
- Other SSAs – whilst there has not been a lot of joint work between SSAs to date, they are beginning to identify areas of common interest where coordination and information sharing might be useful.
- District Health Boards NZ (DHBNZ) – links range from being non-existent to being mutually aware of the work programmes of each organisation and taking a lead role in a variety of national issues and forums.
- Ministry of Health – this relationship has varied in quality, from “fantastic” to “difficult”. SSA involvement most often occurs when SSAs act to support collaborative processes between DHBs and the Ministry for services the Ministry still plans and funds.

- Communities – SSAs are not directly involved in community consultation but may support and advise DHBs on community consultation for planning and funding of services.

Issues for SSAs:

Conflict between individual DHBs and regional interests: SSAs remain neutral and can act as a mediator between different DHBs.

National issues requiring attention: Although the SSAs usually work for individual DHBs, they can represent groups of DHBs in national forums.

Entrepreneurial spirit: Having become specialised units, some SSAs are looking to build their business and operate outside of their shareholder base. Not all shareholding DHBs like this development, seeing it compromising the availability of the SSA to work for shareholders. SSAs working outside their shareholder groups do so on a fee-for-service basis.

Competitiveness: Since DHBs have stopped SSAs seeking business outside the shareholder base there is little competition between SSAs. As a result, SSAs have set up strategic alliances to take advantage of the particular specialist abilities of their sister SSAs.

Future of SSAs:

During SSA establishment, DHBs committed funds for only short periods of time, giving them the opportunity to evaluate their continued investment in SSAs. SSAs do not view this short term funding as a signal of their demise. However they do report tensions among DHBs over funding for SSAs. There is an expectation that the roles of SSAs will change to meet the differing needs of DHBs. The development of PHOs and population based funding are likely areas of new work for the SSAs. SSAs consider themselves to be essential extensions of the DHBs particularly in planning services where regional knowledge is necessary.

To try and ensure a future, SSAs have tried to identify ways to remain useful and responsive to shareholding DHBs. These include:

- Ensuring the expectations of the owners and clients are identified and met.
- Recognising and respecting planning and funding decisions as the responsibility of the DHBs.
- Ensuring SSAs are competent and able to give quality and objective advice to the DHBs.
- Ensuring SSAs are committed to proactively identifying threats and opportunities within the health sector.
- Tailoring service delivery to meet the specific needs of each DHB.
- Ensuring SSAs operate a ‘no surprises’ approach in all services to DHBs.

Appendix 10

Summary on Regional Mental Health Networks

1 Introduction

When the health reforms established the District Health Board (DHB) structure, the Mental Health Commission (MHC) expressed concerns about DHBs acting independently without consideration of national and regional interests and undermining established regional specialist mental health services. The MHC also was concerned that DHBs would not treat mental health as a priority. The MHC recommended maintaining the regional mental health services structure. The Ministry of Health accepted this advice and required the establishment of four Regional Mental Health Networks.

The purpose of this research was to explore the ways in which the Networks are working. This report was summarised from the earlier full report of Jo Davis, a visiting researcher at the Health Services Research Centre in 2002. This research will be followed up in the ongoing project to check the consistency of these results and how the Networks have evolved.

2 Methods

This research was based on document analysis from DHBs and the Networks, a literature search, and six interviews with key informants. These were:

- A senior government official from Ministry of Health
- A representative from the Mental Health Commission
- The four managers who work to support the administration of the regional Networks.

The same interview schedule was used for all for the managers supporting the Networks.

Notes were written up of each of the interviews and circulated to each interviewee. Alterations to the notes made by the interviewee were accepted. Non-response was taken to indicate approval of the contents of the notes.

3 Findings

The four Regional Mental Health Networks are Northern, Midland, Central and South. These Networks are comprised of the same DHB composition as the equivalent shared support service agencies, and in some instances these parallel RMNHN and SSA regional organisations share personnel and infrastructure.

The Ministry has defined the role of these regional Networks:

- The production of regular regional plans and the allocation of additional ring fenced mental health funds on the basis of this regional planning
- Service planning
- Quality improvement
- Workforce development
- Improved collaboration.

Mental health has some unique characteristics which affected the decision to continue planning on a regional basis. These include:

- The *Blueprint* (national mental health service development plan)
- Ring-fenced funding
- Workforce and skill shortages

- Diversity of agencies involved in mental healthcare
- Fragmentation of services and high NGO involvement
- Newly established (or planned) specialised services for small numbers of patients/clients
- Existence of Mental Health Commission with national focus.

There is some confusion as to the mission and purpose of Networks. DHB documents reflect confusion over the purpose of the Networks, with many simply referring to the Networks as required by the Ministry, and one DHB was reported as stating that clarification of the relative roles of the Ministry, DHBs and other organizations was the first major challenge for strategic mental health planning. Sector informants also expressed frustration at the lack of guidance about the purpose of the Networks.

The Networks have defined their purpose in different ways. The Southern Network has stated the purpose as improving the configuring of services and building on inter-district co-operation. The Central Network, and similarly Northern, stated the overall purpose is to ensure effective services across the region. The Midland Network has adopted a more detailed rationale, which includes the above objectives, plus improved access to services, increased Maori participation and equity across the DHBs.

The four Networks have developed independently of each other and do not have a lot of contact. They have adopted quite different organisational systems, which include DHB representatives, with differing levels of stakeholder involvement. However in all cases the Network generates recommendations with all final decision-making remaining the responsibility of the individual DHBs.

3.1 What the Networks Have Achieved So Far

All four Networks have focused more on funding and planning, as compared to workforce development, quality improvement and service integration and collaboration.

At the time of the research, the Northern Network was relatively undeveloped due to a pending review of mental health services in the Auckland region by the Mental Health Commission. This Network was about to develop strategic plans. Midland had developed a regional plan but the Network manager and local stakeholders alike considered the consultation had been inadequate. Midland had allocated additional mental health funds, and was undertaking research to assess the regional services against the *Blueprint* standard. Central was found to be the most highly developed of the four Networks, and had allocated funds, consulted with stakeholders, developed a regional plan, and were carrying out a stocktake of each DHB against the *Blueprint*. They also had nine key projects underway focusing on key aspects of service development. The Southern Network had regional service planning projects underway, but with little emphasis on consultation compared to the north island Networks. This Network had suggested a method of allocating *Blueprint* funding and developed a detailed five year regional plan.

3.2 Strengths

Although it is too early to say how well the Networks are working, many of the people involved in the Networks are very positive about them and give examples of specific benefits which have resulted from working within them.

Many staff reported how well DHBs had been able to co-operate and to forgo individual gain for the wider benefit of the region. Of particular note is the benefit of sharing scarce specialist expertise and the development of cross-DHB relationships which have been helpful in times of trouble. The Networks were seen as enhancing equity and facilitating more coherent planning over a larger area.

The Networks can facilitate the development of new regional specialist services, to improve access to specialist services across the region. Other benefits include the development of co-operation and co-ordination between different services, and improved involvement of stakeholders.

3.3 Weaknesses

- Informants identified a number of problems across the Mental Health sector:
- Acute workforce shortages
- Poor access to regional services by some patients
- Duplication of services across DHBs
- Low involvement of key stakeholders
- Difficulties in establishing quality monitoring frameworks
- Poor communication between services.

The roles of the Networks, as defined by the Ministry, can be seen as an attempt to address these problems. However informants also identified weaknesses they associated with the Networks, including:

- Conflict between DHB and regional priorities
- Low levels of technical planning expertise
- Existing funding inequities within regions
- Cross-boundary charging and inequitable contributions to regional services
- The potential for power struggles between DHBs and Networks.

All of these have been identified as having the potential to destroy the sustainability of the Networks.

4 Conclusions

Although there is some confusion about their purpose, informants report that the Networks have already provided some benefits to the sector. Those involved seem committed to making them work and report a willingness among DHB representatives to act co-operatively and look at regional solutions to issues. Some people involved in the sector consider some historical barriers and divisions have already been repaired by the development of the Networks. These include links between community and specialist services, and DHBs and NGOs.

This research was conducted at an early stage of Network development. The evolution of the Networks will be monitored in the ongoing research. The divergent functions of the four Networks will also allow comparison across regions.

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