



Health Reforms 2001 Research Project

Report No. 1

**HEALTH REFORMS 2001 RESEARCH:
OVERVIEW REPORT**

Nicholas Mays, Jacqueline Cumming, Tim Tenbense

On Behalf of the Health Reforms 2001 Research Team

August 2007



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Introduction to the Health Reforms 2001 Research

In 2001, the New Zealand government introduced reforms to the structure of New Zealand's health and disability sector. Under the New Zealand Public Health and Disability Act 2000, the government introduced a number of overarching strategies to guide the health and disability sector and it established 21 District Health Boards as local organisations responsible for population health and for the purchasing and provision of health and disability support services at a local level.

In 2002, funding was provided to chart the progress of, and to evaluate, these reforms as they were implemented. The research took place between 2002 and 2005. This paper is one of a series reporting on findings from the research. The papers in the series focus on:

- *Health Reforms 2001 Research: Overview Report*
- *Governance in District Health Boards*
- *District Health Board Strategic Decision Making*
- *Financing, Purchasing and Contracting Health Services*
- *Devolution in New Zealand's Publicly Financed Health Care System*
- *Māori Health and the 2001 Health Reforms*
- *Pacific Health and the 2001 Health Reforms*
- *Overview Report of the Research in Five Case Study Districts*
- *Print Media Reporting of the DHBs*
- *Performance of New Zealand's Publicly Financed Health Care System: A Focus on Performance Under the New Zealand Public Health and Disability Act (2000)*
- *Public Sector Management and the New Zealand Public Health and Disability Act*

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Executive Summary

Introduction

In 2001, the New Zealand government reformed New Zealand's health and disability support services sector. Under the auspices of the *New Zealand Public Health and Disability Act 2000* (NZPHDA), the government sought improvements in the health of the population and reductions in health disparities for Māori and other population groups. 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 and disability support sectors. Other Strategies have also been developed, including *He Korowai Ōranga/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 government 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, via service agreements. Third, the reforms involved a shift away from a 'quasi'-market model to a more collaborative set of arrangements for purchasing and providing health and disability support services with a stronger community voice in relation to decision making about health and disability support services.

This overview report brings together the findings from a series of reports on specific aspects of the reforms produced by the Health Reforms 2001 Research team. This report summarises the accounts and views provided by the large number of people who were interviewed and surveyed for the study and summarises analyses of routinely available quantitative data to answer the following overarching research questions:

- To what extent is the NZPHDA model achieving the goals set by the government and the goals of other stakeholders in the public system, particularly in relation to the aspects which were the specific foci of the research?

- What are the strengths and weaknesses of the NZPHDA model? How can the model be improved?
- What are the strengths and weaknesses of the NZPHDA model compared with the quasi-market model of the 1990s in terms of achieving government goals and those of other stakeholders?

The Health Reforms 2001 Research was focused particularly on evaluating the process of reform; i.e. on how the new (NZPHDA) model centred on the new DHBs was being implemented; and how well it was operating from the perspective of a wide range of people working within the system.

The findings are presented thematically, organised primarily around the topics identified as fundamental to the NZPHDA model when the research was designed.

Research Design and Methods

The research was undertaken between 2001 and 2005 and involved research at all 21 DHBs as well as more detailed case studies in five districts. There were two rounds of interviews and postal surveys in 2002/03 and 2004/2005. The DHB-wide data collection covered the expectations and experiences of those involved in implementing and working within the NZPHDA model. It relied on documentary analyses; key informant interviews with ministers, ministerial advisors, officials, national stakeholders (e.g. representatives of NGOs) and commentators; a postal survey of DHB Board members; interviews with DHB Chief Executive Officers (CEOs) and Chairs; and interviews with DHB Planning and Funding managers. The experiences and expectations of Māori and Pacific peoples were a particular focus of the research.

The research also drew on wide range of relevant statistics in order to identify trends in key indicators of health system performance before and after the introduction of the NZPHDA model (see Mays and Cumming, 2007).

The data from repeated interviews with a wide range of different stakeholders at all levels in the system revealed a variety of views on many subjects, and these are set out in greater detail in the series of reports focused on individual themes (as listed above). In this overview report, only important differences of view are described.

Findings

One of the most striking findings to emerge from the research was the widespread support among interviewees for the main goals and mechanisms embodied in the NZPHDA model. In particular, there was strong support for the local focus of DHBs, including their role in assessing the needs of their local populations, the emphasis on community engagement through elected board members and a statutory requirement to consult the population. There was also strong support for the various national strategies developed following the initial legislation, primarily the New Zealand Health Strategy, Māori Health Strategy, Disability Strategy and Primary Health Care Strategy. There was also support for aspects of the DHB model such as the requirement for boards to conduct their business in public and the focus on collaboration rather than rivalry between DHBs in their roles as purchasers and providers of services, as well as the opportunities for greater integration between different services.

Many respondents reported a cautious optimism that in the long run the 2001 model would lead to real benefits. The repeated emphasis on improving ‘population health’ (even if how to do this was not well defined or necessarily well understood) resonated with many stakeholders. This is not to say that there were no criticisms of the system; rather that criticisms tended to focus on the specifics of arrangements rather than on the underlying principles, objectives and mechanisms associated with the model.

Respondents generally supported the policy of funding each DHB in line with the needs of its population on the grounds that this was more likely to produce an equitable allocation of resources than a central purchaser allocating funds to providers through the contracting process as under the previous, ‘quasi’-market system. However, there were some residual concerns about the population-based funding formula, such as whether it adequately reflected the differences in costs of services faced by different DHBs.

A key aspect of the research has been on issues relating to Māori health, the Treaty of Waitangi, and Māori experiences of the NZPHDA model introduced into Aotearoa/New Zealand in 2001. The key issue for Māori working under the NZPHDA model is the relationship and responsibilities between the Crown, Ministry, DHBs and Māori, all within the context of the ongoing poor health status of Māori. This research has found the general view of participants to be that the degree of commitment to Treaty obligations varies across agencies. The research also identifies positive support for *He Korowai Ōranga*, but many participants report a lack of funding required for proper implementation and confusion over what *whānau ora* actually means and hence, how it is put into operation. Key issues for Māori providers are inadequate funding and contracting of their services and inadequate support and understanding of the models of care they employ; there was a clear expression that ‘by Māori, for Māori’ health care is the preferred model.

Key issues in improving Māori health then, concern re-iterating the importance of the Treaty of Waitangi, ensuring sufficient resources for Māori health, ethnicity data collection, and continued attention to upskilling and supporting the Māori health and disability workforce.

Improving Pacific health was one of the key goals of the New Zealand Health Strategy, supported by a Pacific Health and Disability Action Plan (PHDAP) (Minister of Health, 2001b). The research found that, although it is difficult to say that the reforms have had a major influence on the overall health status of Pacific peoples, there are strengths in the NZPHDA model which have had major impact on the service delivery for Pacific peoples and there is also more representation of Pacific people at governance level.

Conclusions

The Government's objectives in 2001 for the reformed public health system as they related to changing the way in which the system was organised and governed have in large part been met. That is, the reforms have focused attention on the health of the population as a whole; the government's Strategies play a key role in setting the direction for the sector; and the local focus of the model along with a greater community orientation and collaborative approach (at least among public providers) is strongly supported by those working in the sector.

However, the governance, management and accountability in New Zealand's publicly-funded health sector since 2001 have become more multi-faceted, and therefore, more complex and sometimes more opaque in comparison to the 1990s. On the other hand, the findings from the research indicate that none of the problems generated by the greater complexity of the NZPHDA model have proved so serious or insuperable that they have threatened the integrity of the public health system. Indeed, it is striking how much continuity there has been. Nonetheless, difficulties have been encountered, particularly in defining the appropriate roles and relationship between the centre (Ministers and the Ministry of Health) and the DHBs, and in determining the extent and timing of the devolution of funds and responsibilities from the Ministry of Health to the DHBs.

The evidence from the research into the post-2001 model and its predecessor suggests that far from there being one best way of governing and organising accountability for publicly-financed care, there is likely to be a variety of feasible approaches, but none pre-eminently superior on all criteria of performance. Different systems seem to give rise to different trade-offs between different desirable health system objectives. Put very broadly, it appears that the post-2001 system is no more efficient, and may be somewhat less efficient, than its predecessor, but is likely to be somewhat more equitable and more popular with system stakeholders and the general public than the previous arrangements. The system has more opportunities for public involvement in decisions, but little sign of greater democratisation to this point.

Overall, however, the extent to which this profile of performance is definitively due to the intrinsic characteristics and incentives of the DHB system rather than secular trends in health technologies, trends in funding levels and other parallel policy initiatives, is impossible to ascertain.

Successive Labour-led Governments have not so far been able to realise all the objectives of the NZPHDA model. The research has shown, for example, that the elements in the new model designed to increase transparency, community engagement and a balanced consideration of issues (by requiring majority elected DHBs to have disability and community and public health committees in addition to a hospital committee and regular consultations on their plans) have not always been as effective as hoped.

The reforms have also ushered in a broader range of accountability criteria and relationships which better reflect the particular characteristics of publicly financed health services. The 2001 model is not an elegant design, but the current system acknowledges the tensions between different types of accountability for the direction of health policy and the use of public resources. The ‘realism’ of the model does entail some risk of a system without strong internal challenge to the status quo but this is less than the risks of a more elegant model that sits uneasily with the complexity of the health sector.

1 Introduction

The performance of health systems is typically assessed in terms of broad criteria such as effectiveness, efficiency, economy (cost containment), equity, responsiveness, acceptability and sustainability. A moment's reflection reveals that systems are unlikely to excel on all criteria simultaneously. Indeed, in many cases there are clear trade-offs between dimensions of performance and their related objectives. Similarly, major reforms of health systems tend to emphasise particular aspects of health system performance and while their proponents rarely, if ever, admit that their reforms might involve trade-offs, this is usually so (Brownell, Roos and Burchill, 2001). As a result, most accounts of the impact of health system reform are in the form of multi-criteria report cards rather than global assessments.

Indeed, much of the data collected for the research on New Zealand's public health system reforms of 2001 introduced following the New Zealand Public Health and Disability Act (NZPHDA) 2000, bears witness to such trade-offs between the different objectives inherent in different ways of organising and managing the system. For example, the new model most obviously highlights the trade-off and tension between equity of access to services and national consistency on the one hand, and local decision making and local responsiveness to population needs on the other (see below).

This overview report brings together the findings from a series of reports on specific aspects of the reforms produced by the Health Reforms 2001 Research team. The current report summarises the accounts and views provided by the large number of people who were interviewed and surveyed for the study as well as summarise analyses of routinely available quantitative data to answer the following overarching research questions:

- To what extent is the NZPHDA model achieving the goals set by the government and the goals of other stakeholders in the public system, particularly in relation to the aspects which were the specific foci of the research?

- What are the strengths and weaknesses of the NZPHDA model? How can the model be improved?
- What are the strengths and weaknesses of the NZPHDA model compared with the quasi-market model of the 1990s in terms of achieving government goals and those of other stakeholders?

In order to present the findings briefly, in contrast to the much longer reports on individual aspects of the research, the findings are presented thematically, organised primarily around the topics identified as fundamental to the NZPHDA model when the research was designed. The data from repeated interviews with a wide range of different stakeholders at all levels in the system revealed a variety of views on many subjects. Where there are important differences of view, these are described. Where either the differences of opinion were relatively minor or only a small proportion of respondents adhered to them, these nuances are largely ignored in this overview.

2 The 2001 Health and Disability Support Sector Reforms

In 2001, the New Zealand government reformed New Zealand's health and disability support services sector. Under the auspices of the *New Zealand Public Health and Disability Act 2000* (NZPHDA), the government sought improvements in the health of the population and reductions in health disparities for Māori and other population groups. 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 and disability support sectors. 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 government 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, via service agreements. Third, the reforms involved a shift away from a 'quasi'-market model to a more collaborative set of arrangements for purchasing and providing health and disability support services with a stronger community voice in relation to decision making about health and disability support services.

These developments followed more than a decade of reforms in the health and disability sectors. During the 1980s, area health boards (AHBs) were established from hospital boards and the Department of Health's regional offices of public health. AHBs eventually came to be governed by a mix of elected and appointed board members, and were tasked with planning services across their populations, as well as with running hospital services. During the early 1990s, the system was radically reformed and a 'quasi-market' model was established. The Department of Health became a policy-focused Ministry of Health. Four regionally-based purchasing authorities (Regional Health Authorities or RHAs) became responsible for planning and purchasing all services. They purchased health and disability services from service providers, through

formal contracts and in an environment which encouraged competition between providers, both government-owned and private for- and not-for-profit. The provider arms of the 14 AHBs were transformed into 23 government-owned hospital providers (Crown Health Enterprises or CHEs). These were charged with business-like behaviour and expected to earn a profit to be returned to the Crown. The boards of the government-owned RHAs and CHEs were appointed by Ministers. In 1997/8, this model was reorganised, with the four regionally-based purchasers amalgamated into a single national, purchaser of services (the Health Funding Authority or HFA), CHEs becoming Hospital and Health Services or HHSs, (with less emphasis on profit-making), and a refocusing on collaboration between providers as opposed to competition.

3 Methods

The Health Reforms 2001 Research was focused particularly on evaluating the process of reform; i.e. on how the new (NZPHDA) model centred on the new DHBs was being implemented; and how well it was operating from the perspective of a wide range of those involved (there is some discussion of system performance below, but this was not an explicit objective of the research).

There are a number of reasons for this prime, but not exclusive, focus on process rather than outcomes: firstly, because the Government's *main* objectives for the new model appeared to relate to *how* the public system functioned rather than on what it achieved (e.g. the reintroduction of locally elected boards was justified primarily on democratic grounds rather than because elected members would necessarily take better decisions and improve population health more than non-elected boards, though this was perhaps implicit); secondly, because so much of the routinely available performance management data in the system, which the research team had no alternative but to rely on, was process-oriented; and, thirdly, because it is very difficult unequivocally to attribute changes in treatment outcomes or health outcomes at the population level to changes in the organisation and governance of the health system such as those brought about by the NZPHDA. Linking institutional features of health systems to their performance is a tricky undertaking and rarely attempted (Greene, 2004)

There are two reasons why it is difficult to attribute changes in outcomes to system reforms: many factors other than the health system affect population health; and other changes have occurred subsequently in parallel with the reforms brought about directly through the NZHDA. For example, the level of funding available to the public health system continued to rise in real terms during this period and a three-year funding 'track' was established to make it easier for DHBs and others to plan their staffing, investment in facilities, etc. These developments were not mandated in the NZPHDA, yet may well have enabled DHBs to improve services more easily than their predecessors, though with the exception of 2000/01, the annual percentage

increases in real expenditure were slightly lower than in the period 1996/97-1998/99. In addition, there were major, parallel developments during the research period, not intrinsic to the DHB model, in particular, the implementation of the Primary Health Care Strategy (subject of a separate evaluation¹). Although it is still too early to tell definitively what impact the Strategy has had on population access to services and health, it is likely that the very large investment in primary care (\$2.2 billion over the seven-year roll-out period, 2001-08), will have had a positive effect. Despite the fact that part of the responsibility for implementing the Strategy fell to the DHBs, the gains made (e.g. admissions to hospital averted by better access to primary care) are not necessarily attributable to the design features of the NZPHDA system.

A final reason for mainly process-oriented research relates to the likely timescale within which measurable benefits (and harms) would become apparent. Arguably, if the new model were to produce measurable benefits, these would most likely not become apparent in the four years covered by the research (2001-05).

Despite these limitations, this overview summarises the research team's attempt to assess trends in health and treatment outcomes, and other quantitative measures of performance such as efficiency, equity and responsiveness, before and at intervals after the introduction of the NZPHDA model, in order to cast some light on the possible impacts of the changes. The full details of this analysis are provided in Mays and Cumming (2007).

The research was undertaken between 2001 and 2005 and involved research at all 21 DHBs as well as more detailed case studies of five Boards. The DHB-wide data collection covered the expectations and experiences of those involved in implementing and working within the NZPHDA model. It relied on documentary analyses; key informant interviews with ministers, ministerial advisors, officials, national stakeholders (e.g. representatives of NGOs) 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

¹ See www.vuw.ac.nz/hsrc for further information on the evaluation of the Primary Health Care Strategy.

experiences and expectations of Māori and Pacific peoples were a particular focus of the research. There were two rounds of interviews and surveys in 2002/03 and 2004/2005.

In five DHBs, more detailed case studies were undertaken involving additional documentary analysis; interviews with a range of DHB staff in both funding and provider arms of the DHB; interviews with non-DHB providers and community stakeholders and commentators; and observational research at DHB Board meetings. The experiences and expectations of Māori and Pacific peoples were also a particular focus of this stream of research.

Finally the research drew on wide range of relevant (published and unpublished) statistics in order to identify trends in key indicators of health system performance before and after the introduction of the NZPHDA model (see Mays and Cumming, 2007).

Interview, qualitative survey data and documentary data were analysed thematically, while quantitative survey data were analysed using descriptive statistics. Findings across the data sources were integrated, compared and contrasted to produce an overall interpretation of the reform process and impacts.

More information on the Health Reforms 2001 Research and its methods is set out in the supporting reports (listed above). As a result, specific reports from the research are not always cited in the text that follows. Each specific report contains more detailed information on the specific methods used.

4 Acceptability and Support for the NZPHDA Model

One of the most striking findings to emerge from the research was the widespread support among interviewees for the main goals and mechanisms embodied in the NZPHDA and subsequent changes, particularly features such as the local focus of DHBs, including their role in assessing the needs of their local populations, the emphasis on community engagement through elected board members and a statutory requirement to consult the population, and the various national strategies developed following the initial legislation, primarily the New Zealand Health Strategy, Māori Health Strategy, Disability Strategy and Primary Health Care Strategy. There also seemed to be strong support for aspects of the DHB model such as the requirement for boards to conduct their business in public (some board chairs felt that open meetings constrained debate, but this did not seem to have become a major issue in practice) and the focus on collaboration rather than rivalry between DHBs in their roles as purchasers and providers of services, as well as the opportunities for greater integration between different services. Perhaps because of the emphasis in the field work on interviews and surveys of participants in the new system, there was little criticism of the removal of competitive pressures (such as they were) between the public hospitals. The picture would most likely have looked different if former managerial staff and board members involved in the pre-2000 system had been systematically interviewed as to their views about the functioning of the DHB system.

While there appeared to be widespread support for the shift towards a less competitive model within the publicly financed health system, many non-DHB providers remained wary of the potential consequences for themselves of the fact that DHBs had become both purchasers and providers of hospital and related services. They feared that DHBs as purchasers would tend to favour their own provider arms unfairly over non-DHB providers (see below for evidence on whether this appeared to be so or not).

The vast majority of stakeholders supported the shift from a single national purchaser (the Health Funding Authority (HFA)) to 21 local DHBs of varying sizes. The only exceptions were some Māori and Pacific Island provider respondents who preferred dealing with the HFA because of its supposed clearer focus on the implications of the Treaty of Waitangi for health services and its greater concentration of purchaser expertise in Māori and Pacific peoples' health issues and service delivery. By contrast, DHBs were viewed as much more Pakeha-driven and much less aware of, and responsive to, the requirements of these providers and their communities of interest.

Many respondents reported a cautious optimism that in the long run the 2001 model would lead to real benefits. It was as if the truly aspirational parts of the new model such as its repeated emphasis on improving 'population health' (even if how to do this was not well defined or necessarily well understood) resonated with many stakeholders. This is not to say that there were no criticisms of the system; rather that criticisms tended to focus on the specifics of arrangements rather than on the underlying principles, objectives and mechanisms.

This suggests that whatever the limitations of the current publicly financed health system (see below for a discussion of the performance of the system), it appears to operate in a way that is closer to the values, culture and aspirations of more people working in the health sector than the previous quasi-market arrangements of the 1990s (though, of course, many of those who were unenthusiastic about the Labour reforms moved out of the health system in 2000-01 or failed to find a place in the new order). The more extreme rhetoric of competition and business methods associated with the previous system does not appear to have been deeply rooted in the hearts and minds of most people working in the system or looking on. Put simply, the current model appears to be more congenial to more people including the general public (as seen in the Commonwealth Fund's annual international health survey which shows an increase in public support for the system compared with the situation in 1998 (see below for more on this) (Schoen, Blendon, DesRoches, et al, 2002; Schoen, Downey and Osborn, 2003; Schoen, Osborn, Huynh, Doty, Davis, Zapert and Peugh, 2004).

This was also borne out in a survey carried out in 2001 in the early stages of the current research (Health Services Research Centre, 2001). The system seems to inspire greater public confidence, perhaps because health professionals are more reconciled to the system than in the recent past. Again, compared with the mid/late-1990s, the level of media coverage of conflict and concerns about performance appears to have fallen. This may partly explain the public's more favourable response since much public concern (as opposed to patient experience) about the health system is mediated by the mass media.

Another major reason why the system seems to have attracted a higher level of support is that it represents, in large part, a reversion to a previous way of doing things familiar from the Area Health Boards (AHBs) of the 1980s which were similarly majority locally elected, and, likewise, had simultaneous responsibility for planning local services for a geographically defined population and for managing local publicly owned hospitals and related services. Whereas the 1993 reforms were presented as a radical attempt to break the mould and to challenge inherited ways of thinking and acting in the public health system, the 2001 reforms were able to be presented as unthreateningly restorative and healing after a period of conflict in the system.

Of course, one has to be careful interpreting the interview and survey responses of even a very wide range of different stakeholders involved in the current system. Most likely the people who were most wedded to the previous way of working and/or most closely identified with the previous era had already left or been replaced by the time the research began. In similar vein, it is worth noting that there was considerable support for aspects of the quasi-market model, if not for the whole package. For example, a number of respondents believed that the HFA had already shown considerable potential as a well informed purchaser before it was abruptly abolished, thereby scattering a critical mass of staff with very scarce expertise and experience, some of whom were lost to the sector.

Another factor that may explain the relatively high level of expressed support for the 2001 system relates to the fact that respondents most likely realised that, barring very major problems in the system, the new arrangements were a *fait accompli* and that no amount of criticism of the new system or dwelling on the finer points of the former system would make a great difference to the government's commitment to its new system. The largest opposition party stated at a relatively early stage that it would not engage in a restructuring of the system if it were to regain power.

5 Making the New Model 'Work'

Consistent with the broad base of support for the principles, goals and methods of the new system, the research documented the many ways in which participants worked constructively to overcome some of the potential weaknesses in the DHB system by developing the model.

The research shows the large investment of time and effort required to implement major reform of the health sector. Though there was no support for any significant further change, there are indications from the interviews of where governance processes might be streamlined and costs taken out of the system.

Encouraged by the terms of their annual Crown Funding Agreements with the Minister of Health, Boards responded to downsides such as the potential for weak financial and clinical risk management, duplication, excess cost, fragmentation and lack of capability with 21 DHBs for a population of under four million people by developing a range of new forms of collaboration such as shared services agencies, Regional Mental Health Networks (RMHNs) and lead purchasing arrangements (though they had to be prompted to build collaborative organisations in some cases). Once in place, these were reported to be particularly valuable to the smaller DHBs, though it may be that these forms of collaboration could and should be taken further. DHBs also established DHBNZ – an incorporated society established and funded by DHBs to enable collaboration in areas of joint interest and potential benefit. By 2005, when data collection ceased, DHBNZ had worked most significantly on industrial relations and workforce development issues on behalf of DHBs.

As a result of these developments, respondents, who often suggested, as a matter of principle, that there were too many DHBs, became less concerned to take any steps to reduce the number. This is because ways had been found to work round the limitations of the system without organisational restructuring, at least from the perspective of most participants. Perhaps it is not surprising that there was little taste for any further structural upheaval in the public system after the turbulence of the

1990s. Even critics of the Labour-led governments have largely abandoned the idea that there are obvious or easy organisational reforms available to transform the system. Also the self-interest of most interviewees was against abolishing and merging DHBs. Indeed, DHB staff expressed concerns about any possibility of forced mergers of DHBs on the grounds of the upheaval that this would create to no great advantage.

In general, the costs of major system change need to be better recognised and provided for in any future reorganisation. There is significant elapsed time required for the implementation of reform, including capacity building in key areas such as governance, planning and funding, and central policy and management. The skill, time and commitment required of Chairs of DHBs have also been found to be critical to success.

6 Governance of DHBs

The prime purpose of governance is to support the aims of an organisation and ensure its accountabilities. Research into governance focused on the roles and responsibilities of the governing Board, relationships between the organisation and key stakeholders (such as the government and the local community), and relationships between board members and staff. This research focused on a number of dimensions of DHB governance processes and performance, including statutory arrangements, Board processes and functioning, and performance of governance roles.

The changes to health system governance were perhaps the most obvious changes brought about by the NZPHDA. In general, the research showed that the new arrangements provided part of what the Government had sought; namely, functioning local boards focused on delivering national strategies and health system goals. The new model was less successful in its first four years in involving the local communities in governance and decision making through democratic processes in new ways, although a more open culture of decision making appeared to be developing in terms of how staff and board members interacted with communities and with providers of services. DHBs are required to engage with their local communities (for example, in developing their plans) and strive to do so. This appeared to be easier to bring about in the DHBs with smaller populations.

In general, participants (and not just board members and senior managers) were reasonably positive about the new governance system and it appeared to be functioning tolerably well in that there was no push for wholesale change. The worst fears of critics (e.g. resignations of board members, problems with open board meetings etc.) did not seem to have materialised and reports from many quarters (not just the DHBs) indicated a significant improvement in how boards were functioning between 2001 and 2004/05 despite some conflicts and tensions with the Ministry of Health, and some more recent concerns over conflicts of interests not always being well managed. No boards were replaced in the first four years. In addition, turnover of board members, which had been a concern given the technical nature of many of

the issues dealt with by boards and their dual accountabilities to the local population and the Minister of Health, was less than expected between 2001 and 2004 at 35%. Most chairs from 2001, whether elected or appointed board members, were reappointed to their positions by the Minister in 2004, suggesting that their performance was regarded favourably. In 2001, 36% of the elected members had been on the interim DHBs appointed to manage the transition to the new system, and in 2004, 56% of incumbents were re-elected (Gauld, 2005).

However, turn-out was low in the DHB elections and fell between the first elections in 2001 and the second set in 2004 from 50% to 42%, broadly in line with the fall in turn-out in local government elections in general. In part, this may well have been a consequence of the shift from 'first past the post' with geographic seats within DHBs at the 2001 election to STV (single transferable vote) system with candidates elected 'at large' in 2004 (Gauld, 2005). The latter was unfamiliar and is more complex to grasp and implement than 'first past the post' from the voter's point of view. High candidate numbers and low turn-out meant that most DHB members were elected by a very small number of votes.

The number of candidates halved between 2001 and 2004 from 1084 to 518 competing for 147 places, despite the financial incentives to become a board member. Perhaps this fall was the result of a growing recognition of the complexity and responsibility of the role. Some board members commented on the tension inherent in being locally elected, but accountable to the Minister of Health for the performance of the DHB and for delivering national policy.

There had been concerns board members facing conflicts of interest, for example, because the NZPHDA permits DHB staff to stand for election to DHB Boards. So far, only a small number of DHB employees have been elected to boards (in 2004, 12% of those elected were employed by the same DHB) and those who did make it tended to have other qualifications than simply being on the staff, such as being involved in wider community activities and organisations, or having had previous directorial or governance level experience either in business or the health sector. Besides employees, the NZPHDA permits the election to the board of any resident, including private health practitioners or contractors who may have a commercial or

professional interest in the outcome of DHB decisions. The risks potentially associated with this were noted in relation to general practitioners on boards.

The percentage of Māori elected board members rose from 3% in 2001 to 8% in 2004, though in both years Māori were somewhat under-represented requiring the addition of Māori members by Ministerial appointment. The ability of the Minister of Health to appoint Board members was also important in regard to other groups such as the Pacific Island population.

Despite the view that the small size of boards (11 members) meant that the Minister had too little scope to fill skill or representation ‘gaps’ among the elected members, chief executives generally declared themselves satisfied with their boards’ abilities. There had been strong management support for, and investment in, board members’ knowledge and skills. Board chairs, in particular, reported being active in trying to ensure that their members were equipped to do the job.

There had been some concerns that boards with elected and appointed members would be divided and not able to take collective responsibility for decisions. Chairs gave no indication that any tensions between different sorts of members could not be handled satisfactorily.

In relation to the statutory committees that boards had to establish to ensure that non-hospital business did not dominate the DHB, there was a general view that they worked well, but some chairs and chief executives would have liked greater flexibility in terms of which committees they were required to establish. Hospital dominance was reported to be declining as the other committees responsible for community health became more experienced.

There were mixed views about the benefits of boards meeting in public. DHB respondents became more relaxed over time about the presence of the public and some boards gave members of the public formal speaking rights during the course of meetings. However, public involvement at meetings was sparse. Some respondents felt that the richness of the debate among board members was harmed by meeting in public, but there were no obvious signs of decisions having been adversely affected by this.

In terms of engaging with their local communities, beyond the electoral process, boards reported variable experience with some concerted efforts to engage local communities in dialogue about plans. Most board members reported that they had little scope for strategic leadership and so it would have been disingenuous to have raised expectations in the community that it could make a major difference to the priorities and actions of the DHB. Most DHB members argued that their foci were given by the Government, and were primarily to minimise deficits and implement Government priorities.

Finally, despite criticisms of the relatively large number of DHBs from a number of quarters, there appeared to be little or no support for forced, centrally planned mergers of boards. The overwhelming preference was to continue the process of building alliances and collaborative ventures between DHBs.

7 Funding of DHBs

Respondents generally supported the policy of funding each DHB in line with the needs of its population on the grounds that this was more likely to produce an equitable allocation of resources than a central purchaser allocating funds to providers through the contracting process as under the previous system. However, there were some residual concerns about the population-based funding formula, in particular, concerns about whether it adequately accounted for differences in the cost of providing services between different DHBs and whether payments made for inter-district flows sufficiently compensated providing DHBs for the cost of providing outpatient services to patients from other DHBs. Disparities in access to services between DHB populations may be perpetuated if some DHBs face unavoidably higher costs that are not recognised in the formula and are thus unable to provide the same level of service as other DHBs. The difficulty in analysing this potential problem lies in being able to separate externally driven cost variations from inefficiencies between boards.

Another concern voiced by some was that the policy of encouraging DHBs to focus on the needs of their resident populations could inadvertently lead them to give lower priority to meeting the needs of patients from other DHBs, particularly when the providing DHB faced funding difficulties. It is not clear whether this concern can be supported by any objective evidence. Indeed, if properly remunerated on a per treatment basis, it might well be in the financial interests of a DHB to provide services to patients from other DHBs since such treatments would provide additional revenue at a marginal cost whereas services to residents would have to be met from within the DHB's weighted capitation allowance.

8 Strategic Decision Making and Planning

Strategic decision-making in the New Zealand health sector has become an increasingly prominent concern since the early 1980s. This concern has been driven by an array of factors, including broader public sector management reform, attempts to reorient the health system towards a greater recognition of the importance of population health, and a desire to widen and deepen the role of local communities in health system decision-making.

The organisational environment, however, presents many challenges for the development of strategic decision-making. The health sector is notoriously difficult to steer, and the capacity of DHBs to set and implement strategic direction is constrained by many factors that are often beyond their control. DHBs are simultaneously accountable to two audiences – central government and their local electorate. The government has made it clear that DHBs' primary responsibility is to implement government policy and has designed the tension into the system in the expectation that it will be productive rather than destructive.

The research found that DHBs clearly moved towards a more strategic focus on population health goals and the needs of their resident populations rather than concentrating exclusively on running public hospitals. There is no doubt that there has been a significant cultural shift in the health sector towards a greater understanding of the importance of serving populations. It would be surprising, and a major policy failure, if this were not the case given that DHBs are organised territorially. Nonetheless, the introduction of DHBs has helped to direct this focus on population health at a more local level than would otherwise have been the case. Relatedly, there is significant support within the health sector for the broad vision of the New Zealand Health Strategy.

Boards became more proficient in their key strategic roles over the four years of the study, but planning and priority setting was a big challenge, particularly in the early years. There was considerable variety in how DHBs approached their planning and priority setting though all believed that the requirement to undertake regular population health needs assessments was useful (Coster, Mays, Scott and Cumming, 2007). DHB respondents reported that their planning processes gave far more emphasis than they would have done in the immediate past to trying to involve the community and NGO providers than in the recent past, but there was significant variation in the degree to which DHBs emphasised this part of the planning process. Respondents gave examples of how community input had affected board decision making, but this was not widespread.

Strategic and annual planning, and prioritisation was undertaken with varying degrees of enthusiasm and proficiency during the period of the research, and DHBs varied in how useful they claimed to have found the dual processes of strategic and annual planning. In the five case study DHBs, community representatives tended to view the plans as documents produced by the DHB for the benefit of central government rather than the basis of a local set of relationships. They judged that they had little likelihood of influencing the content of plans in a major way. One obvious reason for this was that plans tended to mirror national priorities and strategies. Instead, community input and its impact was most visible in relation to the detailed design of specific local services.

The research showed that plans were only indirectly related to the specific resource allocation and purchasing decisions made by DHBs. In particular, despite their avowed utility, health needs assessments were generally not closely linked to the prioritisation process and resultant decisions on priorities. In part, it appeared that this was because many of the needs assessments were better characterised as population 'health profiles' rather than analyses capable of identifying the requirements of the district population for specific services (Coster, Mays, Scott and Cumming, 2007). All DHBs developed processes for establishing their priorities, though none of the processes operated continuously or comprehensively.

When prioritisation was explicitly pursued, it was only considered feasible to prioritise the use of ‘new’ or additional funds which could be used to develop additional services. There was no interest in reviewing expenditure as a whole or in considering cutting established programmes in order to expand others, perhaps because managers recognised how difficult both analytically and politically this could be.

DHB board members and managers consistently reported that they had little flexibility to respond to the needs and priorities of their communities, and that they were highly constrained in their strategic decision making by Government opposition and community resistance to any disinvestment they might contemplate. It is hard to discern to what extent this was a ‘true’ perception tested repeatedly or a rationalisation designed to avoid any risk to the board.

Where boards appeared to have been given some freedom, they did not always welcome the fact. So, while complaining at the degree of central interference in DHB priority setting and strategic decision making, DHBs (and relevant NGOs) also complained about the *lack* of central guidance and support to implement the changes associated with the various national strategies (there are 30 current strategies affecting the NZPHDA sector). Generally, each DHB agreed its priorities for services based on the New Zealand Health Strategy and other strategies, the Ministry’s strategic priority service areas, the Minister of Health’s short-term priorities, an Operational Policy Framework from the Ministry of Health, and lastly the DHB’s own preferences. DHBs received strong messages from the Ministry of Health that the Government’s priority objectives had to be reflected in Districts’ five-year Strategic Plans.

While broadly supporting the direction and content of the strategies, respondents from many different organisations tended to criticise them for being too ‘high level’, for setting excessive expectations, and for lacking a clear indication as to how they could be implemented. Respondents from DHBs and other local service providers reported wanting more guidance and support given what they perceived as the scale of innovation and change required by the strategies. This apparent contradiction between wanting guidance as well as local flexibility in implementation may be explained by the fact that DHB respondents reported that strategies were hard to

implement except when they were accompanied by dedicated, additional funding (such as in the case of the Primary Health Care Strategy). It is possible that board members and senior managers did not believe that they would be supported if they were to reallocate resources from existing programmes to implement national strategies. They consistently reported that organisational factors such as organisational remits, boundaries, funding streams and work practices constrained their ability to meet the objectives of the strategies in the short term. Their complaints about the lack of guidance on strategy implementation may also be interpreted as an indirect criticism of the number of strategies published from 2001. There was also direct criticism of the confusion generated by the sheer number of different strategies issued by the Government and the Ministry of Health since 2001 and a sense that some of them were poorly integrated (particularly the Primary Health Care Strategy, the Disability Strategy and the Health of Older People Strategy).

9 DHB Purchasing and Contracting

The assessment of DHB purchasing and contracting from the perspective of participants in the system depended on whether respondents worked in the statutory (DHB) or non-governmental sectors.

There was wide, but not unanimous, support for the goal of shifting purchasing of personal health services from the single HFA (latterly the Ministry of Health) to 21 DHBs on the grounds that decisions would be more responsive to local variations in need and that DHB decision making would be more transparent than either the HFA's or the Ministry's. Errors in national contracts as they related to local service delivery were also picked up in the transition to DHB contracting for personal health services, which providers welcomed.

Opinion was substantially more divided in the case of public health and disability support services. Many public health and disability support services are provided by national organisations and so for these groups, devolution meant negotiating and contracting with multiple agencies, rather than a single organisation (the Ministry). This is likely to increase costs and may fragment service provision. There was some evidence from the research that the review and restructuring of disability support contracts for aged care would have been substantially more straightforward to accomplish at national level rather than involving 21 DHBs. However, some NGOs reported that their experiences of contracting with the Ministry had not always been positive, with reference to inflexibility and uneven power relationships. Some thought that the DHBs or their regional agencies might be more responsive and open to negotiation.

In general, aged care providers preferred to deal with individual DHBs than with the Ministry of Health even though initially DHBs lacked the information and expertise to contract effectively. National advocacy organisations were the exception, for the obvious reason that no individual DHB had a particular interest in funding them since all benefited potentially from their work.

Most non-governmental providers reported that relationships between purchasers and providers had become closer and they seemed to appreciate the more flexible, relational style of contracting that DHBs were encouraged to pursue in the new, collaborative system. Non-governmental providers generally reported that their contracts were less bureaucratic, longer term and less costly to manage though there was still the uncertainty as to whether they would be renewed. Though competition between publicly owned providers had been eliminated from the reformed system, there was still competition between non-governmental providers for contracts to provide public services.

Where non-governmental providers particularly parted company from DHB respondents was in their assessment of the fairness of the current arrangements. They generally perceived that there was a power imbalance between the stronger DHB and the weaker NGOs and that the DHBs, regardless of their intentions, gave preference to their own provider arms when this was not always justified (see below). NGO providers also argued that they were additionally unfairly disadvantaged because they had to cover their entire costs, including their costs of capital, from within their contract prices whereas public providers had access to separate capital funding from the Government. Overall, the NGO sector tended to believe that contract negotiations and the basis for the allocation of contracts by DHBs were opaque. Some respondents argued that DHBs should have written tendering policies to prevent accusations of bias and that the Ministry of Health should be more active in monitoring DHBs' contracting decisions. The issue of the fairness of contracting between NGO and DHB providers remains a live issue, in part because of the difficulty of determining the extent to which NGOs are disadvantaged.

The criticisms from NGO providers are scarcely surprising given the way in which DHBs as purchasers are vertically integrated with the public hospitals in the new model and given the history of public investment in the public hospital system. Not only do DHBs have direct responsibility for the consequences of their purchasing decisions in so far as they affect the services provided by public hospitals, but non-governmental providers operate in a competitive or at least contestable market whereas public hospitals do not. On the other hand it is more difficult to find clear evidence that DHBs have discriminated against non-DHB providers. For instance, the overall proportion of work undertaken by publicly owned providers fell from 58% in 1994/95, to 52% in 1999/2000 (just before the current reforms) and remained at 52% in 2002/03, largely due to a reduction in the provision of psychiatric services through public hospitals (two years after the DHBs came into existence).

10 Devolution of Funds and Decision-Making to DHBs, and the Adaptation of the Role of the Ministry of Health

‘Devolution’ can be defined as the creation or strengthening of sub-national levels of government which are substantially independent of national level for some defined set of functions (Mills 1990). In New Zealand, planning, resource allocation and management functions have been restructured a number of times over the past 20 years, with the latest reforms – the establishment of 21 DHBs responsible for population health and for the purchasing and provision of health and disability support services at a local level – presented as a form of devolution.

A key feature of the NZPHDA model was to be the gradual devolution of funding and decision-making to DHBs in order to increase local participation in decision-making. This devolution was to take place within a framework in which DHBs were formally accountable to the Minister of Health as the former HSSs had been and where DHBs were to work within national frameworks, including the New Zealand Health and Disability Strategies.

One of the most pervasive themes running through the research was the sense among participants outside the Ministry of Health that the original goal of instituting a ‘devolved’ (to use the term most widely used by respondents) health system had yet to be achieved for the most part. Almost all DHB respondents agreed that Ministers and the Ministry of Health had so far strongly controlled what was on the policy agenda at local level and restricted the ‘decision space’ of DHBs, particularly in relation to setting local priorities, to a degree that was inconsistent with the government’s own policies and goals for the system, as they saw them. Indeed, a number of respondents argued that there were signs that the degree of central control and scope of upward accountability requirements were increasing rather than reducing despite the fact that DHBs were gaining in experience. For example, the approval and development of primary health organisations (PHOs) as part of the implementation of the Primary Health Care Strategy, had been led by the Ministry of Health and had largely excluded

DHBs, being rolled out at a faster pace than could be managed at local level despite the fact that it had significant implications for DHB strategies. Furthermore, fewer Board members in the 2004/05 DHB Board member survey agreed that the DHB had sufficient autonomy and more DHB Board members agreed that there were times when the Ministry and government interfered inappropriately in the work of the DHB than had been the case in the 2002/03 survey. Some DHB board members complained that the Ministry of Health had vetoed solutions to dealing with DHB deficits in Annual Plans because they would involve rationalisation of facilities and/or services, despite the fact that boards were required to eliminate deficits. Board members also wanted to be able to determine their own Board sub-committee structures rather than being required by legislation to have hospital, community and public health, disability support advisory and audit, risk and finance committees.

It was common for respondents at DHB level to complain about the large number of competing strategies and other policy documents emanating from the Ministry of Health (attributed to the 'siloed' organisation and style of working of the Ministry), onerous reporting requirements (especially for the smaller Boards) with too little emphasis on outcomes, the lack of feed back on performance and, in particular, the decision to delay the 'devolution' of funds for public health to DHBs (i.e. to postpone when DHBs would be able to take responsibility for these resources and their associated purchasing decisions). This last was seen by most DHB respondents as particularly inconsistent with avowed policy since DHBs are statutorily required to take a public health approach to improving the health of their populations, yet did not control the budget for public health which had been retained by the Ministry of Health. What the Ministry of Health might have regarded as understandable caution was seen by DHB board members and staff as showing a lack of trust in their capability and/or not valuing their local knowledge as much as they might. There was also a pervasive view at DHB level that the very size of the Ministry of Health and balance of its staffing skewed the system towards central control and that the Ministry had not adapted enough to the needs of the new system. However, even at DHB level the view was not unanimous that DHBs should have responsibility for the public health budget and elsewhere in the sector views were even more divided in relation both to public health and disability support budgets. The budget for disability support services (social care) of those over 65 years of age was shifted from the Ministry of

Health to the DHBs in October 2003 after considerable debate. There had been significant problems with this in the short term including the ability of the DHBs to take on the financial risk involved and manage the contracts that they inherited. On the other hand, DHB respondents were optimistic that they could deal with these problems.

Understandably, Ministry of Health respondents were less comfortable with a highly devolved model and more aware of the political risks that the Minister of Health could be exposed to under such a model if things went wrong. At central government level the tolerance of risk is generally very low. This appears to be because Ministers are heavily criticised for perceived policy failures, but much less likely to be praised and rewarded for their successes. This experience inevitably reduces the taste for risk taking.

One of the difficulties in assessing the validity of the criticisms made by many DHB level respondents that the system was insufficiently 'devolved' relates to the general lack of clarity in the use of terminology in this field. There is a wide range of definitions of terms such as 'decentralisation', 'deconcentration', 'delegation' and 'devolution'. In addition, there is frequently confusion as to how such phenomena relate to concepts such as 'authority', 'autonomy' and 'discretion'. Finally, there is frequently little clarity as to which aspects of the process of government are at issue in decentralisation (i.e. 'what' is being decentralised - inputs, processes or outcomes?) (Peckham, Exworthy, Powell and Greener, 2005). The 'where', the 'what' and the 'how' (the nature of the relationships) are all problematic. Peckham et al argue that Bossert's (1998) notion of 'decision space' or room for manoeuvre (in this case of DHBs, perhaps mostly in their purchasing role) is perhaps the most useful way of thinking about whether the relationship between DHBs and the Ministry/Minister has become more or less decentralised. It appeared that there was little or no scope for DHBs to increase their 'decision space' in relation to inputs (e.g. resources) or in relation to outcomes (e.g. health objectives). The more contested terrain related to the processes (e.g. priorities and decisions) taken by DHBs and the degree of freedom they experienced in being held accountable for pursuing different means to achieve common objectives (e.g. as set out in the New Zealand Health Strategy). Here, the evidence from the research hints that respondents did have a case and that the

intentions set out in the NZPHDA had yet to be fully met. For example, the Ministry of Health was still responsible for the funds for public health and certain budgets were still ‘tagged’ or ‘ring-fenced’ for particular purposes (e.g. in mental health) to prevent DHBs making their own decisions on local priorities. Arguably the decentralising aspects of the reforms were over-emphasised as an obvious way of distancing the new system from the previous National-led coalition’s approach, especially its decision to adopt a single purchaser, but this has generated a tension between the notion of a bureaucratic, hierarchical system and a more ‘communitarian’ system with far less central control. As a result, there is a continuing need to develop and refine the monitoring framework for DHBs and clarify the allocation of decision making responsibilities between the DHBs, other agencies and the Ministry of Health.

However, it must be remembered that there is no guarantee that a more decentralised system will necessarily be a better one. There is very limited empirical evidence linking any dimension of health system performance and the degree of decentralisation of its decision making (Peckham et al, 2005). The 2001 model rests on strong, positive assumptions about the benefits of decentralisation, but what little evidence there is tends to be equivocal at best and difficult to apply from one context to another. Much of the evidence of the positive effects of decentralisation comes from low income countries and systems shifting from very high levels of central direction.

11 Māori Health

A key aspect of the research has been on issues relating to Māori health, the Treaty of Waitangi, and Māori experiences of the NZPHDA model introduced into Aotearoa/New Zealand in 2001.

The Ministry of Health/Manatū Hauora and District Health Boards have clear responsibilities in relation to Māori health and the principles of the Treaty of Waitangi, under the NZPHDA. The key issue for Māori working under the NZPHDA model is the relationship and responsibilities between the Crown, Ministry, DHBs and Māori, all within the context of the ongoing poor health status of Māori. This research has found the general view of participants to be that the Ministry is not meeting its Treaty obligations, that they should have relationships at all levels of infrastructure (whānau, hapū and Iwi), and that more consultation is required. DHB and PHO intermediary groups are also viewed as unhelpful and the degree of their commitment to Treaty obligations varies.

The research identifies positive support for *He Korowai Ōranga*, and participants provided a number of examples of new activities resulting from *He Korowai Ōranga*. However, many report a lack of funding required for proper implementation. The key component of *He Korowai Ōranga* and *Whakatākaka* is the concept of whānau ora, but there is some confusion over what whānau ora actually means and hence, how it is put into operation.

The need for improved ethnicity data collection was a key theme identified throughout this research. Although generally under-represented, the actual number of Māori in the health and disability workforce is uncertain due to this poor data. Some initiatives are making progress in this area, however. Retention and training are also acknowledged as important and DHBs similarly report varying levels of success here.

Key issues for Māori providers are inadequate funding and contracting of their services and inadequate support and understanding of the models of care they employ, by their DHB. There are also many capacity issues. Some found DHBs helpful however, and report an improvement in working with the community. There was a clear expression that ‘by Māori, for Māori’ health care is the preferred model.

In some DHBs a clear commitment to Māori health is indicated through initiatives such as Treaty workshops for staff, Māori health managers, Māori representation on committees, and community consultation. Although intentions for Māori health are perceived to be clear, and government strategies such as *He Korowai Ōranga* are being employed by some Boards, in other cases DHB members believe there is little more than ‘lip service’ being paid to Māori health; some DHBs are seen as unsupportive and not cognisant of the Treaty. Barriers include staff capacity, lack of guidance on strategies, different understandings of whānau ora, and lack of resources.

Māori DHB members interviewed agreed their role is to ensure the interests of Māori are advanced. However, some are unclear of the DHBs’ actual Treaty obligations as opposed to the Crown’s. In general, Māori DHB members feel they work well with other DHB members, are well supported, and consider their Boards to be well informed. However, there were concerns raised over racist attitudes and DHBs not acknowledging or validating Māori health and Māori strategies.

When comparing the NZPHDA model to the HFA/THA model, overall the NZPHDA model has support from those interviewed. Some continue to express greater support for the HFA model where it was likely growth of Māori providers was greater and there was a ‘by Māori for Māori’ identified group working on Māori health. Some Māori providers perceive that the NZPHDA does not allow for the “same level of communication” as the HFA model did, and while the NZPDHA model has seen the development of relationships at local level, there remains a concern that the Treaty relationship really lies with the Crown and not the DHB.

The research has found that the key issues in improving Māori health then, concern re-iterating the importance of the Treaty of Waitangi, ensuring sufficient resources for Māori health, ethnicity data collection, and continued attention to upskilling and supporting the Māori health and disability workforce.

12 Pacific Health

Improving Pacific health was one of the key goals of the New Zealand Health Strategy, and this goal is supported by a Pacific Health and Disability Action Plan (PHDAP) (Minister of Health, 2001b). The research found that, although it is difficult to say that the reforms have had a major influence on the overall health status of Pacific peoples, there are strengths in the NZPHDA model which have had major impact on the service delivery for Pacific peoples. Furthermore, improvement has been made at governance level in relation to more representation by Pacific peoples.

One strength of the NZPHDA reforms is the relationships that have developed between some DHBs and Pacific communities. These relationships are supported by official policies and strategies on how to engage with Pacific communities, and the importance of utilising a culturally appropriate approach to invite the perspectives of the Pacific communities. This suggests that awareness and understanding about Pacific health issues has increased in some of the DHBs.

Other important forms of relationships beneficial to Pacific peoples are those between the Pacific board members and Pacific managers in the seven DHBs with a significant Pacific population. These meetings held every two months are opportunities to share information about workforce issues and to provide moral support for each other. The Pacific unit within the Ministry of Health also run bi-monthly meetings with Pacific DHB members.

The PDHAP was identified as one of the strengths of the new model allowing Pacific health issues to be brought out into the public arena formally. While some respondents felt excited about the plan, others were not impressed commenting that the PDHAP had not make a difference to the health status of Pacific people overall.

Respondents also concluded that the election process for board members was failing Pacific communities. Suggestions from Pacific communities as to how to select Pacific board members could minimise appointing members that are not fully committed to developing relationships and representing Pacific peoples.

The development of the Pacific workforce has accelerated compared to previous years under other models. Most respondents felt that more resources should be put into developing the Pacific workforce. More resources should aid an investigation into identifying key workforce initiatives that will create a platform for sustainable workforce development for Pacific people.

Some providers spoke of their inability to provide an appropriate Pacific model of care and support for families and clients because of limitations imposed by a funding formula that is not suitable to all Pacific providers. Providers argued that their levels of funding level had remained the same, but the number of people they were required to care for had increased and continued to increase. Some contracts continue to be on a year-by-year basis yet have been held for a number of years.

Pacific providers said that they were committed to providing services that are more acceptable and appropriate to Pacific people. They also argued that 'mainstream' health services should not only be accessible and appropriate to Pacific people, but also acceptable. Pacific respondents spoke of working long hours not only as nurses and community health workers, but also as translators and interpreters. These skills should also be recognised and included in service contracts.

13 Performance of the New Model Compared with the Quasi-Market of the 1990s

In their different ways, the other facets of the health reforms 2001 research have shown that the post-2001 model, though very different in terms of governance from its predecessor, has continued to provide satisfactory health services available to the public of New Zealand without encountering major problems of system cohesion and stability. In other reports from the research, participants described a gradual maturing of systems and relationships, marked by a greater sense of trust between purchasers, providers and regulators. The period since 2001 has demonstrated that it is possible to provide a reasonably comprehensive range of modern health services through the agency of 21 statutory entities, the majority of whose members are locally elected and subjectively accountable to their local populations not to central government. Far from 21 majority locally elected DHBs inducing incoherence or even policy anarchy, it has proved possible to pursue a New Zealand Health Strategy and to use it as an organising framework within which each DHB draws up its strategic and annual plans, and purchases health services for its population in light of local needs.

However, beyond issues of reform process and system stability, the outstanding questions are whether the performance of the more collaborative, locally accountable public health system has changed since 2001 and whether it is possible to identify any association between the post-2001 model and trends in health system performance. Given that the health system provides a very heterogeneous range of services for many different purposes; that system performance is multi-dimensional; that good data are not available on all the aspects of performance of interest; and that health system performance is shaped by a wide range of external (e.g. social, economic and environmental factors) and internal factors (e.g. technology, spending and staffing) many of which are unrelated or only partly related causally to a specific set of system 'reforms', this is far from straightforward.

The high level answer is that there are some signs of performance improvement in certain areas and either a deterioration of performance, or halting of improvement in performance, since 2000/01 in other aspects of the system. The new system did not have dramatic impacts and there were strong signs of continuity with the previous period. The observable trends suggest that the public health system shows some signs of greater equity of access to services; better financial performance in terms of deficit reduction; no obvious sign of efficiency improvements and possible reductions in some areas; some signs of an improvement in responsiveness in high profile areas such as electives; and a higher level of public acceptability, all occurring against a background of substantial real terms expenditure increases (see Mays and Cumming (2007) for more detail on trends in specific indicators of performance).

There are a number of possible explanations for these findings. First, it is apparent that few of the structural and governance changes instituted in 2001 were likely to have had immediate, major impacts on clinical staff and the pattern of their day-to-day work, and this was, indeed, found to be the case. As a result, any impacts on health services delivery will have taken time to accrue. Indeed, in many cases, there are still only two or three years of post-DHB performance data available upon which to make a judgement and in part of this period, the new system was still either being implemented or bedding down. In addition, reliable time series from even the mid-1990s to date do not exist in many areas of performance.

Second, in relation to trends in efficiency and effectiveness, specifically, the 2001 reforms came after two decades of improvement in hospital efficiency and effectiveness as measured by routine indicators such as falling length of stay and the increase in the share of day case treatment. These trends were similar to those observed in many high income countries and most likely related to the application of technological innovations allowing bed reductions to occur without compromising the quality of care as much as to the particular organisational and managerial contours of the health care system (Hensher, Edwards and Stokes, 1999; Carriere, Roos and Dover, 2000; Brownell, Roos and Burchill, 2001).

Third, by historical standards, the health sector enjoyed relatively large year-on-year funding increases in the later 1990s and beyond, ahead of the growth in national income, which eased the transition to the new system and may have obscured all but the most obvious effects of changing the organisation and incentives in the system from 2000/01. Even so, there is some evidence from a Treasury (2005) analysis of the early post-reform period that the incentives to increase measured hospital patient throughput and productivity may be less obvious and quality little or no better in the DHB hospital system than under the previous system based on a purchaser-provider split allied to payment of public hospitals according to their outputs (using national diagnosis-related group (DRG) prices). This may be because post-2001, DHB provider arms (hospitals) negotiate internal service level agreements with DHB purchaser arms. Output reimbursement is reserved for the treatment of out-of-district patients which represents a small part of the income of most public hospitals. It is a distinct possibility that external contracting is more effective in signalling quality and efficiency improvements to providers than internal service level agreements between parts of the same organisation. Alternatively, it may be that the previous quasi-market system simply encouraged providers to record their outputs more assiduously since they were paid for each patient treated up to certain thresholds and that this incentive was reduced after 2001.

Fourth, the government unobtrusively retained a number of elements of continuity with the previous regime that reduced the contrast between the two eras (Ashton, Mays and Devlin, 2005). For example, the HFA's 'Service Coverage Document' which had set out in some detail what the public could expect from the public health system and thus what purchasers should commission, found its place in the newly devolved DHB world. In theory, its survival was contrary to the idea of a system of devolved planning and purchasing of services with DHBs undertaking their own health needs assessments, determining local priorities and planning their purchasing accordingly, but it provided a helpful framework for the new DHBs.

The strongest sense at the health care delivery level was of continuity of established trends and large amounts of ‘business as usual’. Consistent with this, DHB staff and members generally reported that they had limited levers of change available and that their scope for change even in relation to implementing national strategies was highly circumscribed. Community input to local decision making in the research period was also limited to the design of particular services rather than setting overall priorities. Likewise, DHB board members reported that they had made less progress than they had hoped for on very difficult issues such as reducing inequalities in population health in their areas, improving the degree of integration between primary and secondary care, community involvement in decision making and the social inclusion of disabled people. This is scarcely surprising given the large amount of work reported by DHB chairs to establish DHBs in the first place before they could focus on their main local health problems. From this perspective, a large part of the period covered by the research can justifiably be seen as the establishment phase of the new system.

14 Managing a Complex, Hybrid Health System

Setting aside the publicly financed health system, New Zealand already has a relatively large and complex government system with 40 central government departments, 73 Territorial Authorities and 12 regional councils. In total there are over 3000 Crown entities receiving state funding (<http://www.teara.govt.nz/NewZealandInBrief/GovernmentAndNation/6/en>). While the post-2001 health system is arguably better suited to the culture of the health professions and the expectations of the public, it is a less straightforward system than its predecessor since its architecture embodies an explicit attempt to balance a range of objectives in tension. This is shown most obviously in the dual felt and legal accountability of DHBs to their local populations and to the Minister of Health, which is a product of the simultaneous commitment to both a decentralised health system responsive to local variations in needs and consistent, equitable access to health services regardless of where people live in the country. DHB members and staff, and staff in the Ministry of Health, portrayed themselves in interviews as constantly trying to negotiate a course between these contending objectives with varying degrees of success.

Another aspect of the complexity of the new model lies in the relatively large number of DHBs each of which is responsible for purchasing and providing a large proportion of publicly financed health services, plus a variety of regional and inter-DHB bodies and networks (e.g. RMHNS). Many interviewees perceived this as a potential weakness of the system. By contrast, under the previous system, not only were there far fewer purchasing entities, but none of the purchasers was responsible directly for any provision. In addition, both public purchasers and public provider organisations were unambiguously upwardly accountable ultimately to the Minister of Health.

Instead of relatively simple roles and accountabilities, the new system of governance explicitly tries to reflect the underlying complexity of a public health system with local, 'felt' accountability to local people, voters, patients and carers, and formal accountability to the Minister via the Ministry of Health, and thence to Parliament and eventually to New Zealand's taxpayers. Though only a minority of board members maintained consistently that their accountability was to their local communities and not to the Minister of Health, the majority was aware of the tension in their role.

The new model is essentially a hybrid since it does not conform strictly to corporate, bureaucratic or philanthropic traditions of governance. Governing and managing in this sort of environment requires the ability to tolerate uncertainty (e.g. when DHB elections produce a new board members), ambiguity (e.g. in attempting to define a workable boundary between what is within the scope of local decision making and what is the prerogative of the Minister and Ministry) and contradictions (e.g. between a DHB remit to improve population health, but without control over public (population) health funding). There is also more risk of conflicts of interest which have to be guarded against and managed. For instance, employees of the DHB or contractors, can be elected as board members, thereby potentially occupying a position to influence decisions affecting their own employment or contracts (though fewer were elected in 2004 than in the first set of elections in 2001). In addition, DHBs' pricing and 'make or buy' decisions in respect of hospital services may be swayed by the fact that DHBs employ the staff at their hospitals and have to manage the consequences if clinical work is diverted elsewhere or deficits accrue. In addition, there may be conflicts of opinion between board members who identify with specific local constituencies and those who identify with the DHB population as a whole.

Thus the new system is more obviously built on compromises than its predecessor. As a result, it calls more obviously for the type of leadership and management skills more often associated with those trained and experienced in the public sector such as strong political awareness and the ability to negotiate with a wide range of contending interests in order to build a constituency of support for a decision, rather than more typical private sector management and leadership attributes such as calculated risk taking and decisiveness.

It is impossible to say whether the greater cost of running such a system is worth it since it depends on how much the Government and local communities value the existence of local DHBs and their ability to take into account local sentiment, however imperfectly.

15 Risks Inherent in the Model

The fact that the new model works more obviously with the grain of the health sector and its values, carries with it its own risks, as some respondents pointed out. The over-riding risk in a system with relatively few internal critics, a focus on collaboration rather than contestability and competition, and where the same leading party has been in government for three terms is of a cosy consensus not given to self-criticism and insulated from external challenge. Specifically, there were perceptions and concerns expressed that DHBs were hospital-dominated and that public health, disability support, and the needs of Māori and Pacific Island groups were subordinate to the priorities of the hospital with little or no countervailing pressure built into the system. Respondents from NGOs, in particular, believed that DHBs tended to favour their own provider arms over other providers, though the evidence to support this contention is scanty. On the other hand, Board members reported that hospital dominance was becoming less of an issue as boards became more experienced at focusing on population health issues.

There were other concerns expressed that a succession of inexperienced elected board members voted for by a small proportion of local people every three years would be poorly placed to do anything about this inherited pattern of dominance. In fact, 65% of those elected in 2001 were re-elected in 2004 suggesting that the risk of major turnover had been exaggerated. Others worried that any variations in capability and performance between DHBs could become entrenched in the absence of obvious external pressures on weak DHBs to improve. On the other hand, chief executives of DHBs reported that they were reasonably content with the capability of their board members, though this had necessitated a considerable amount of training and support to achieve.

16 Implications of the Model for Wider New Zealand Public Sector Management

The Labour Coalition Approach to Public Sector Management

One of the main objectives of the 2001 health system reforms was to return the public health system to a pre-market form. The plans were set out in Labour's 1999 general election manifesto and the new Labour-led government began work to change the system almost immediately. Thus health was among the first major public service and arena of government responsibility to be subject of major legislative reform by the new Labour-led coalition government. It was also the first opportunity the government had had to realise its critique of the prevailing public sector management regime.

In opposition, Labour had criticised the public sector management approach of the 1990s for, among other things, an excessive focus on the production, monitoring and accountability for the delivery of outputs (i.e. units of service and activities) rather than desired outcome changes; for encouraging administrative fragmentation with the proliferation of narrowly conceived, single function agencies; for an excessive emphasis on the use of contracts, generating unnecessary transaction costs; for encouraging an inappropriate private sector style of management dominated by business people, accountants and lawyers rather than people who understood public services; for tending to exclude community consultation and input to decision making; and for a disproportionate emphasis on economic incentives as opposed to public service and professional values to improve the delivery of public services. There was also a concern that too many government agencies and boards were too far removed from democratic, political control, and wielded excessive executive, technocratic power.

The new model for the public health system described above reflected the incoming government's desire to move beyond an approach to public sector management directly informed by New Zealand's version of the New Public Management (NPM) (Scott, 2001) towards a more communitarian and complex model of governance, perhaps more reflective of the particular history and context of the public health system in New Zealand.

Three broad strands underlay the approach favoured and adopted by the Labour Party. The first was a return to 'functional integration' and a corresponding rejection of market models that required 'functional separation' (e.g. between purchasers and providers). Functional separation had been a key design principle of New Zealand's state sector reforms (Boston et al 1996) inspired by NPM, but was seen as causing excessive fragmentation. This was the rationale for the abolition of the HFA as a specialist national purchaser, the expansion of functions of the Ministry of Health to become the dominant source of policy advice to the Government, and the creation of DHBs responsible for both purchasing and provision at the local level.

The second strand picked up on the expansion of the 'scope' of public management. The Labour Party, alongside other commentators such as Schick (2001), regarded the reforms of the 1980s and 1990s as fostering an excessive preoccupation with outputs to the neglect of outcomes. However, responsibility for the achievement of improved outcomes is typically shared between a range of governmental and non-governmental agencies. Under the NPM model, the interactions between different agencies were treated formally primarily through contractual mechanisms. This came to be regarded by many as an inadequate basis for dealing with complex policy problems. Instead, co-operative and collaborative relationships between government and non-government agencies, characterised in terms of networks and partnerships, were increasingly favoured.

Thirdly, as has been discussed elsewhere in this report, Labour's policy advocated greater involvement of the community in the formation and delivery of public policies. This marked a return to previous models of health sector governance in New Zealand and also resonated with a greater focus on outcomes in that communities were seen as having a role in 'co-producing' such outcomes.

Perhaps the most obvious challenge to the usual principles of public sector management New Zealand-style was the dual formal legal (upward) and subjective informal (downward) accountability of the new DHB board members. The risk was that this arrangement would cause divided loyalties leading to conflicts between members, particularly between elected and appointed board members, thereby weakening the collective responsibility of the board for effective decision making. There was also obvious potential in the new model for tension and conflict between DHBs, and the Ministry of Health and Minister, since DHBs were charged with assessing and responding to local needs while at the same time working within national strategies and requirements from the centre (see above).

For those who favoured the clearer architecture of New Zealand's original version of new public management, other potential risks of moving in this direction included:

- Conflicts of interest and insufficient objectivity with the Ministry of Health judging the effectiveness of policy and strategy which it had helped produce;
- Reduction in expertise and quality of decision making by boards due to recurrent changes of membership brought about by elections rather than by the needs of the system, the requirement to reserve two places for Māori, the reduction in the number of members appointed by the Minister of Health and the reduced emphasis on relevant skills (e.g. in accountancy, law and management) in favour of local community knowledge;
- Lack of transparency with the abolition of the company form for public hospitals and their incorporation into DHBs;
- Reduced accountability for the efficient use of major Crown assets as public hospitals merged into purchasing organisations;
- Conflicts of interest within the DHB in its dual role as purchaser and as provider of public hospital services leading to poor purchase decisions and reluctance to reconfigure hospital services (e.g. because the DHB would be left with the responsibility for redundant staff);
- Conflicts of interest on the DHB board if staff of the DHB were to be elected onto the board as permitted in the legislation;

- Removal of even weak competitive pressures leading to a reduction in emphasis on service quality and efficiency; and
- The Treaty clause leading to preferential regard for the needs of Māori ahead of other equally needy groups.

However, despite appearing to violate a number of the principles of public sector management as articulated in the late 1980s and 1990s, the 2001 model retained many important features of the previous approach (Ashton, Mays and Devlin, 2005). The changes instituted by the Labour-led government are best seen not as a replacement of New Zealand's version of NPM, but as a supplement to it designed to try to mitigate its characteristic weaknesses. Accordingly, the changes since 2000 have been criticised by both advocates and opponents of the 1980s state sector reforms as an inappropriate mixing of incompatible public sector design principles (Scott 2001; Gregory 2003).

How has Public Management in the Health Sector Changed Since 2001?

The over-riding characterisation of the changes to the governance and management of the public health system since 2001 is of a more complex hybrid of competing forms of management accountability. Hierarchical, market, network and communitarian forms of public management contend with one another.

- 1) Hierarchical forms of public management ('upward') accountability to central government)

There has been no reduction in the importance of hierarchical mechanisms in the health sector since the 2001 reforms. The control mechanisms adopted in 2001 show clear continuity with the 1990s and the locus of control has largely shifted to the Ministry of Health. In particular, the strong emphasis on upward accountability to the Minister of Health for use of resources and pursuit of government objectives in the

health sector has remained. Perhaps related to this, many of the elements of the previous national approach to purchasing were also retained, such as the Service Coverage Document which had specified the services which New Zealanders could expect the HFA to purchase on their behalf under the previous system. It was part of a continuing emphasis on attempting to ensure consistency across the country so that wherever people lived they stood a roughly equal chance of receiving the same services in relation to their needs (see above on devolution). DHB respondents claimed consistently during the research that the combination of the Service Coverage Document, the annual operating policy framework for DHBs issued by the Ministry of Health and the large number of government priorities meant that local purchasers had relatively little scope to alter the inherited pattern of care in any major way.

Indeed, it is significant that DHBs were categorised as ‘agents’ in the 2004 State Sector Amendment (no. 2) Act and Crown Entities Act 2004; the least autonomous form of Crown entity, required to ‘give effect’ to government policy. This indicates that, regardless of the fact that they have a majority of locally elected board members, they are part of the ‘core’ of the state sector and directly accountable to the Minister of Health. The Act thus makes it very clear that DHBs’ independence and discretion in decision making is potentially highly circumscribed depending on the nature and extent of the issues arising. It removes any scope, at least for the foreseeable future, for evolutionary change in the formal relationship between DHBs and the centre in response to growing DHB capability and the accumulation of experience in managing in a supposedly decentralised system.

The 2004 legislation should lead to a clearer delineation of the respective roles and responsibilities of Parliament, the Minister, Ministry, board, board members and managers which ought in principle to reduce the likelihood of arguments about whether Ministers have interfered in DHB affairs inappropriately or problems with conflicts of interest. The Crown Entities Act 2004 should also improve the protection offered to board members in the event of major performance problems, but is also more prescriptive of the standards of governance and care expected of Board members.

2) Market forms of public management ('upward' accountability to purchasers)

Under the current set of arrangements funding of hospital services bears little resemblance to the competitive contractual model attempted in the 1990s. Hospital services are funded in two main ways: service level agreements based on planned treatment volumes are negotiated between the purchaser and provider arms of DHBs for services delivered by the DHB's hospitals to residents of the DHB; and services delivered to non-residents are paid for according to the number of treatments delivered using a tariff of nationally agreed benchmark prices. However, the purchasing function is still relevant for other services in the health sector, particularly those based in the community, and many concerns have been raised by non-government providers as to whether DHB providers had an unfair competitive advantage under the current structure.

3) Network public management ('sideways' accountability to other organisations)

The research has shown that there has been a substantial growth in the significance of network-based mechanisms that are direct or indirect consequences of the restructured health sector. Firstly, the local scale of DHBs has generated a significant degree of networking at the local level. In some DHBs these have taken the form of service planning networks. These local networks are groups set up by DHBs to discuss and resolve issues relating to specific services (e.g. primary health care), and have given an enhanced role for non-government providers. More broadly, government policy, particularly in the area of primary health care, has meant that DHBs need to act as relationship brokers rather than 'directors' in relation to primary health organisations (PHOs). Contracting processes have become more 'relational' and less bureaucratic. Contracts are reported to give more emphasis to the delivery of health outcomes than in the past, although this does not mean that strong linkages between contractual requirements and outcomes have necessarily been established. This is very hard to do in many cases. Within hospitals, the research documented a more collaborative relationship between clinicians and management than had been the case in the 1990s.

Secondly, significant networks have developed between DHBs. DHBNZ has been one of the most notable developments to flow from the reforms in terms of co-operative relationships between DHBs to deal with economies of scale in service delivery, inter-district flows, contractual negotiations and support administrative functions. Following earlier collaborations between the CHEs and their successors, the HSSs before 2001, the growth in importance of DHBNZ is the most visible evidence of this development. This propensity for networks between DHBs is regarded by many in the sector as an effective way of dealing with the problems of small scale affecting some DHBs.

- 4) Community public management ('downward' accountability to local community)

As discussed elsewhere in this report, the scope for community involvement in health sector governance has expanded considerably, though in quite different ways to that envisaged by those who framed the new model. Formal involvement of communities has not, so far, had a major effect on DHB decision-making, at least from the perspective of participants. In part, this was because DHBs varied in how and to what extent they sought to engage with their local populations. The post-2001 emphasis on a more participative style of decision making in public sends out a positive image of the public health system that appears to be more consistent with the values and aspirations of those working in it, but its practical impact has been very limited. This is consistent with the wider literature which shows that formal structures taken alone have a relatively limited impact on decision making (Peckham, Exworthy, Powell and Greener, 2005). The distribution of resources and expertise between government agencies and providers on the one hand, and communities on the other suggests that the scope for meaningful community input and collaboration is limited to small, local scales.

On the other hand, community participation has become more important in service design and delivery, and community organisations often play a role in local service-delivery networks. The growth in local-level networking has been the main driver of increased community participation, and these channels have been more significant than the more formal mechanisms for community involvement in DHB planning.

In practice, community mechanisms tend to mesh with many of the network developments outlined above.

Discussion: Competing Frameworks of Accountability?

In practice, the research has shown that for the health sector as a whole, the two strongest ‘logics of accountability’ are hierarchical and network. Networking mechanisms have flourished at the same time as hierarchical controls have been refined and strengthened. Market mechanisms, though still present for community-based health services, are less important than they were in the 1990s, and community involvement, though more significant than previously, is not yet a strongly discernible source of health sector steering.

The co-existence of networking (accountability to other actors and organisations in networks) and vertical hierarchy (accountability to central government) seems to be a recipe for significant internal tension and possible instability within the health sector. However, in terms of overall policy development and implementation, the competing ‘logics of accountability’ have not directly collided where responsibility for service delivery has been clearly devolved. This can be attributed to a fairly clear delineation, in principle, between central government’s role as developers of policy and the DHBs’ role as implementers. However, as the research into the process of devolution of funding and responsibility to DHBs shows, this theoretical distinction between policy and implementation has been much less clear in practice. Such problems bedevil many hierarchical health systems that aspire to encourage local responsiveness.

Nonetheless, DHBs acknowledge the importance of central government leadership in setting the broad direction, while central government acknowledges that DHBs are better at practically working out how to implement central government strategies. This means that governments should establish the key policy objectives (a hierarchical approach), whereas local and regional networks become salient in working out the practicalities of working towards these objectives. Indeed, rather than there being a perceived overlap of these policy functions (given that there is rarely a neat distinction in most areas of public policy between ‘policy’ and ‘implementation’ or ‘strategy’ and ‘operations’), one of the main issues reported in the research is the existence of a significant gap between general policy frameworks and implementation detail with DHB staff asking for more detail rather than less.

At the local level, the research indicates that a combination of hierarchical and collaborative approaches to contracting has resulted in the specification of contractual outcomes that are perceived to be more appropriate and sensitive to variations in local contexts than would have been possible in the previous period.

Nevertheless, for NGOs, all four broad types of accountabilities are present and can cut across each other. NGO relationships with other providers may be simultaneously co-operative and competitive. They operate in ‘collaboration’ with DHBs, the Ministry of Health and ACC as partners, and at the same time are required to comply with hierarchical accountability requirements. On top of this they are often expected to be responsive to the concerns and perspectives of the communities they represent. While these conflicting roles and relationships are endemic whenever non-government agencies are involved in delivering publicly-funded services, the current structure has the effect of exacerbating these sometimes conflicting requirements by emphasising each type of accountability in different contexts. At a practical level, the need for NGOs to manage and balance multiple types of accountability has the potential to channel too much energy and resources away from actual service delivery.

17 Conclusions

The Government's objectives in 2001 for the reformed public health system as they related to changing the way in which the system was organised and governed have in large part been met. That is, the reforms have focused attention on the health of the population as a whole; the government's Strategies play a key role in setting the direction for the sector; and the local focus of the model along with a greater community orientation and collaborative approach is strongly supported by those working in the sector. A previously nationally-directed and funded system has been given a stronger local identity and more local venues for decision making have been created. As a result, the governance, management and accountability in New Zealand's publicly-funded health sector since 2001 have become more multi-faceted, and therefore, more complex and sometimes more opaque in comparison to the 1990s. On the other hand, the findings of the research indicate that none of the problems generated by the greater complexity of the NZPHDA model have proved so serious or insuperable that they have threatened the integrity of the public health system. Indeed, it is striking how much continuity there has been. Nonetheless, difficulties have been encountered, particularly in defining the appropriate roles and relationship between the centre (Ministers and the Ministry of Health) and the DHBs, and in determining the extent and timing of the devolution of funds and responsibilities from the Ministry of Health to the DHBs.

The evidence from the research into the post-2001 model and its predecessor suggests that far from there being one best way of governing and organising accountability for publicly-financed care, there is likely to be a variety of feasible approaches, but none pre-eminently superior on all criteria of performance. Different systems seem to give rise to different trade-offs between different desirable health system objectives.

Put very broadly, it appears that the post-2001 system is no more efficient, and may be somewhat less efficient, than its predecessor, but is likely to be somewhat more equitable and more popular with system stakeholders and the general public than the previous arrangements. The system has more opportunities for public involvement in decisions, but little sign of greater democratisation to this point. The extent to which this profile of performance is definitively due to the intrinsic characteristics and incentives of the DHB system rather than secular trends in health technologies, trends in funding levels and other parallel policy initiatives, is impossible to ascertain.

Successive Labour-led Governments have not so far been able to realise all the objectives of the NZPHDA model. The research has shown, for example, that the elements in the new model designed to increase transparency, community engagement and a balanced consideration of issues (by requiring majority elected DHBs to have disability and community and public health committees in addition to a hospital committee and regular consultations on their plans) have not always been as effective as hoped.

The reforms have also ushered in a broader range of accountability criteria and relationships which better reflect the particular characteristics of publicly financed health services. The 2001 model is not an elegant design, but the current system acknowledges the tensions between different types of accountability for the direction of health policy and the use of public resources. The ‘realism’ of the model does entail some risk of a system without strong internal challenge to the status quo but this is less than the risks of a more elegant model that sits uneasily with the complexity of the health sector.

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