



Health Reforms 2001 Research Project

Report No. 11

PUBLIC SECTOR MANAGEMENT

AND

THE NEW ZEALAND

PUBLIC HEALTH AND DISABILITY ACT

Tim Tenbenschel, Nicholas Mays and Jacqueline Cumming

On Behalf of the Health Reforms 2001 Research Team

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Table of Contents

Introduction to the Health Reforms 2001 Research.....	v
Executive Summary	vii
Introduction: Change of Government – Change of Emphasis in Public Sector Management.....	1
How has Public Management in the Health Sector Changed Since 2001?.....	10
Hierarchical Forms of Public Management (‘Upward’ Accountability to Central Government).....	10
Market Forms of Public Management (‘Upward’ Accountability to Purchasers).....	11
Network Public Management (‘Horizontal’ Accountability to other Organisations).....	12
Community Public Management (‘Downward’ Accountability to the Local Community).....	14
Implications of the 2004 Legislative Changes for the Health System.....	16
Discussion: Competing Frameworks of Accountability?	20
Conclusions.....	23
References.....	25

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

The Government's objectives in 2000 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. A nationally directed and funded system has been given a stronger local identity and more local venues for decision making have been created.

Accountability in New Zealand's publicly-funded health sector since the 2001 reforms has become more multi-faceted with a mix of hierarchical, network and market forms. As a result, governance is more complex and sometimes more opaque in comparison to the 1990s. The broader range of accountability criteria and relationships seem better to reflect the characteristics of publicly financed health services, in particular, their multiple objectives and the involvement of many interests in their steering and production.

The DHB model is not an elegant design, but the current system acknowledges tensions between different types of accountability for the direction of health policy and the use of public resources. It also appears to be more popular with the public and with health professionals. However, the 'realism' of the model does entail some risk of a system without strong internal challenge to the status quo and without consistent pressures to improve.

Despite the fact that the 2001 model is rooted more obviously in health sector realities, some governance and management difficulties have been encountered, particularly in defining the appropriate roles and relationship between the centre and the DHBs. Those working in DHBs perceived that they had little or no autonomy and were frustrated by the lack of real devolution, at least in the first four years of the new model. In addition, the elements in the new model designed to increase transparency, community engagement and a balanced consideration of issues (e.g. by requiring DHBs to have disability and primary care committees in addition to a hospital committee) have not been as effective as hoped.

1 Introduction: Change of Government – Change of Emphasis in Public Sector Management

One of the main objectives of the 2001 health system reforms was to return the public health system to its pre-market, pre-1990s 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 the public part of the health system was among the first major public services and arenas of government responsibility to receive a Labour-inspired 'make-over'. It was also the first opportunity the government had had to realise its critique of the prevailing public sector management regime.

From the mid-1980s to the middle of the 1990s, New Zealand's system of public sector management underwent fundamental reform. The changes put in place, though a direct response to a practical assessment by Ministers and their advisors of the limitations of the country's government system, were also influenced by globally circulating ideas about the advantages of importing private sector organisational forms and managerial techniques into the public sector. In particular, New Zealand moved to separate policy, funding (purchasing) and delivery (service provision) functions into distinct organisations, and to modify traditional government bureaucracies towards more client-oriented service units facing actual or potential competition (Norman, 2006). In health care, disability support (social and long term care) and education, 'quasi-markets' were instituted in which public funding remained, but public and non-governmentally owned providers competed for service contracts from public purchasers acting on behalf of clients and users.

The 'quasi-market' model for the publicly financed health system involved the Department of Health becoming a policy-focused Ministry of Health. Four regionally-based purchasing authorities (Regional Health Authorities or RHAs) became responsible for planning and purchasing all services for their populations. They purchased health and disability services from service providers, through formal contracts rather than grants, and in an environment which encouraged competition, as far as was practicable, between providers, both government-owned and private for- and not-for-profit. The provider arms of the former Area Health Boards (AHBs) which had owned and run the public hospitals were transformed into 23 government-owned hospital and related services' providers (Crown Health Enterprises or CHEs) funded according to their outputs (patients treated). These were set up as limited liability companies, charged with business-like behaviour and expected, in principle, to earn a profit to be returned to the Crown (though their overriding goal was the efficient production of health care to the public). 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 known as Hospital and Health Services (HHSs), with not-for-profit status and a greater focus on collaboration between providers as opposed to competition.

In opposition, Labour, among others, had criticised the approach of the 1990s for, among other things, an excessive focus on the production of, monitoring and accountability for the delivery of measurable outputs (i.e. units of service and activities) rather than desired outcome changes; for encouraging fragmentation with the proliferation of narrowly conceived, single function agencies; for an excessive emphasis on the use of contracts, generating unnecessary transaction costs and undervaluing intrinsic human motivation to do good; 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.

Informed by this general critique, 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 shifted away from a 'quasi-market' model to a more collaborative set of arrangements for purchasing and providing health and disability support services, and established 21 majority locally elected district health boards (DHBs) as local agencies accountable to the Minister of Health, but responsible for organising health care, and latterly, disability support for the populations in their districts. DHBs undertake periodic assessments of the needs of their populations, plan services for their districts, provide services through their 'provider arms' (public hospitals and related services) and fund services delivered by non-DHB providers. The government also developed a number of Strategies, in particular the two overarching strategies – the New Zealand Health Strategy and the New Zealand Disability Strategy – to provide overall guidance to the health sector, and the Primary Health Care Strategy. In resource terms, the most significant of the strategies has been the Primary Health Care Strategy (Minister of Health, 2001a) which has resulted in a major increase in the financial scope of the public system aimed at improving people's low cost access to primary health care services, in particular, GP services. DHBs are required to work within the framework of objectives set by the national Strategies.

Three broad strands underlay the approach favoured and adopted by the Labour Party, and implemented by the Labour-led coalition government of 1999-2003. The first was a return to 'functional integration' and a corresponding rejection of quasi-market models that required 'functional separation' (i.e. particularly between purchasers and providers). Functional separation had been a key design principle of New Zealand's state sector reforms (Boston, Martin, Pallot and Walsh, 1996), but was seen by critics as causing excessive fragmentation of functions (Gregory 2003; Norman 2003). 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, and the relative importance of outputs versus outcomes of policy. 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 improving outcomes for the population. However, responsibility for the achievement of improved outcomes is typically shared between a range of governmental and non-governmental agencies. Under the New Zealand version of the New Public Management (NPM) model, the interactions between different agencies were treated formally primarily through contractual and quasi-contractual mechanisms. This approach came to be regarded by critics as an inadequate basis for dealing with complex policy issues and problems, and for securing improvements in desired outcomes. Instead, co-operative and collaborative relationships between government and non-government agencies, characterised in terms of networks and partnerships, were increasingly favoured. The language of networks and partnerships emphasised 'heterarchical' rather than hierarchical and contractual relationships between organisations, meaning that agencies were to be encouraged to give greater attention to their 'horizontal' relationships with other agencies at their level in the system as well as their 'vertical' accountability relationships to central government and to Ministers. The clearest example of this was the 'Review of the Centre' undertaken in 2001 which emphasised the importance of collaborative relationships between state sector departments and service agencies the better to address the needs of citizens which cut across the demarcations between government agencies (Advisory Group on the Review of the Centre, 2002).

Thirdly, Labour's policy advocated greater involvement of the community in the formation and delivery of public policies, including in the health field. This led to 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.

This evolving approach to public management reflected recent international empirical and normative developments as well as the ideological preferences of the Labour Party. By the end of the 1990s, many academics and practitioners, particularly in the United Kingdom and Europe, had come to use the term 'governance' in preference to public management to describe the task facing governments in contemporary society. The use of the term 'governance' denotes an increased recognition of the importance of networks and communities (both of the public and of policy makers) in the development and successful implementation of policy. According to this interpretation, networks and communities supplement, and perhaps even supplant previous emphases upon both hierarchical and market-type mechanisms. 'Governance', interpreted this way, denotes a significant shift in understanding of the role of the state sector:

'from a view of state power based on formal authority to one of the role of the state in co-ordinating, steering and influencing; from an interest in the actions of the state to an interest in the interplay of plural actors in both the shaping of policy (through policy networks) and the delivery of services (through partnerships)'
(Newman, 2001: 23)

There was also evidence emerging that certain high profile public services such as education and health care fitted the NPM model less well than other services with more uniform production processes, and more easily observable and measurable outputs and outcomes (Lane, 2000).

The new model for the publicly financed health system reflected the incoming government's desire to move beyond an approach to public sector management directly informed by New Zealand's version of NPM (Scott, 2001) towards a more communitarian and complex model of governance, and perhaps one that was more 'path-dependent' (i.e. rooted in previous norms and structures) and more contextually-specific than its predecessor:

- The New Zealand Health Strategy asserted the importance of focusing on health and improved health outcomes rather than on producing more outputs more efficiently;
- The abolition of a seemingly remote and technocratic, national purchasing agency and its replacement by 21 majority locally elected boards accountable to the Minister of Health for purchasing services for local populations was a way of demonstrating the importance of involving the community more in the system and giving its members a greater say in how their health care was organised and provided;
- DHBs meeting and taking decisions in public was a way of signalling a more open, participative style of health system governance;
- Integration of public hospitals and related public health services into the local DHB purchaser effectively abolished the purchaser-provider split for publicly owned hospital and related services, and ended the Crown company status of hospitals and their monitoring by the Crown Company Monitoring and Advisory Unit (CCMAU) alongside other government-owned enterprises;
- Case-mix funding (i.e. payment by output) of public hospitals ended when they became part of DHBs and was replaced by internal service level agreements plus reimbursement of patients from other DHBs according to a set of standard prices (based on the former case mix system);
- DHBs as purchasers for a territorial population were funded according to a national weighted capitation formula emphasising the relationship between resources and levels of population health need;

- The emphasis on population health needs assessment, local planning and collaboration between providers removed the last vestiges of official support for the idea of pursuing supply side competition within the publicly financed hospital system (though de facto competition remained between non-governmental organisations for other, non-hospital contracts from the DHBs);
- With the abolition of the Health Funding Authority and the ending of CCMAU's role in the health system, the Ministry of Health took responsibility not only for policy and strategy, but also for information, monitoring and performance management of DHBs, purchasing of highly specialised services and regulation of the conduct of the system at national level; and
- The inclusion in the NZPHDA of a Treaty of Waitangi clause – for the first time in a piece of social policy legislation – plus the reservation of at least two places on every DHB for, signalled a recognition of the particular rights of Māori as the indigenous people of New Zealand to protection by the public health system.

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, particularly of those who were elected by locally. The risk was that this arrangement would cause divided loyalties leading to conflicts between members, especially 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.

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

- Conflicts of interest and insufficient objectivity in the system, as shown, for example, by the fact that the Ministry of Health was to judge the effectiveness of the policy and strategy which it had helped produce, and that DHB employees were eligible for election onto DHB boards;
- 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 (reducing the scope to recruit members with specific technical skills as opposed to representative knowledge), the reduction in the proportion of board 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 acting both as purchasers and providers of hospital services;
- Reduced accountability for the efficient use of major Crown assets as public hospitals are merged into purchasing organisations;
- Conflicts of interest within the DHB because of 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 any redundant staff);
- Removal of the remaining weak competitive pressures in the system, leading to a reduction in emphasis on service quality and efficiency; and
- The inclusion of the Treaty of Waitangi clause in the NZPHDA leading to preferential regard for the needs of Māori ahead of other equally needy groups, thereby threatening support for the new system.

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

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

The evidence collected through the Health Reforms 2001 Evaluation between 2001 and 2005 shows that the governance, management and accountability changes to the publicly financed health system since 2001 have led to a more complex, hybrid of competing forms. Hierarchical, network and communitarian forms of public management control contend with one another, and with appreciable inherited elements of the former quasi-market system.

Hierarchical Forms of Public Management ('Upward' Accountability to Central Government)

There has been no diminution in the importance of hierarchical mechanisms in the health sector since the 2001 reforms. The control mechanisms show clear continuity with the upward accountability regime of the 1990s. The locus of control for health sector agencies has shifted to the Ministry of Health, acting on behalf of the Minister of Health in place of the single national purchaser (HFA), but the nature of accountability is similar for the use of resources and pursuit of government objectives in the health sector. 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. DHB respondents claimed consistently during the evaluation 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.

Similarly, respondents from DHBs reported that they were constrained in their use of new resources. This perception conflicted with the ostensible government commitment to a ‘devolved’ health system in which DHBs would be given considerable responsibility and freedom to assess the needs of their population and manage their own budgets accordingly, albeit within a framework of national policies and objectives.

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 are negotiated between the purchaser and provider arms of each DHB 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 were raised by non-government providers as to whether DHB providers had an unfair advantage under the current structure. The evaluation was unable to identify convincing evidence that this was the case.

Network Public Management ('Horizontal' Accountability to other Organisations)

The evaluation showed that there was a substantial increase in the significance of network-based mechanisms that were direct or indirect consequences of the restructured health sector.

Firstly, the local population focus of DHBs has generated a significant degree of networking at the local level. In some DHBs this has taken the form of service planning networks. These are usually local groups set up by DHBs to discuss and resolve issues relating to the planning of specific services (e.g. primary health care). Often these networks formed under the umbrella of statutory committees, particularly the Community and Public Health Advisory Committees of DHBs, many of which involve non-government providers and community representatives on an ongoing basis. These local networks have given an enhanced role to non-government providers that could be seen as at least partly mitigating their concerns about the potential conflicts of interest inherent in DHBs acting both as purchasers and providers of hospital services.

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 new primary health organisations (PHOs). These are non-governmental organisations funded by DHBs to be responsible for ensuring the delivery of primary medical and related services to their enrolled populations by independent primary care providers, including general practitioners. Contracting processes were also reported to have become more 'relational', less bureaucratic, and more focused on outcomes than in the past, though 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, a non-governmental, umbrella body of DHBs, 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 of patients and related reimbursement, contractual negotiations and shared administrative functions. The growth in importance of DHBNZ is the most visible evidence of this development. Although inter-organisational collaboration was also a feature of the 1990s model through the Crown Health Association which represented CHEs and later HSSs, the scope of collaboration has increased with the development of DHBNZ. 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. DHBNZ appears to be an especially valuable resource to the smaller DHBs which find it more difficult to justify providing a comprehensive management infrastructure than the larger boards.

The reforms to public management in the early 2000s were also intended to facilitate greater networking between different government agencies and policy sectors at national level (Advisory Group on the Review of the Centre, 2002). Intersectoral collaboration, however, was not a particular focus of the Health Reforms 2001 Evaluation so it is not possible with the data available to say whether or not this has happened in the health field and what role the Ministry of Health played in facilitating this.

Community Public Management ('Downward' Accountability to the Local Community)

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 strategic decision-making, at least from the perspective of participants; though it is built into their health needs assessment and planning processes. In part, this is because DHBs varied in how and to what extent they sought to engage with their local populations (e.g. as part of the strategic and annual planning processes), in part, because of the government's emphasis on DHBs' roles in implementing national strategies.

The post-2001 emphasis on a more participative style of decision making in public sent out a positive image of the public health system that appeared to be more consistent with the values and aspirations of those working in it, but its practical impact too has been very limited to date (Gauld, 2005). This is consistent with the wider literature which shows that formal structures of local involvement (e.g. local elections and consultative processes) on their own have a relatively limited impact on decision making (Peckham, Exworthy, Powell and Greener, 2005).

The reintroduction of elected members was an important symbol of a shift to community governance. However, the research shows that there was little distinction in orientation between elected and appointed board members, and that responsiveness to central government strategies outweighed the representation of local communities in decision-making. As long as central government remains responsible for funding and service standards, this is arguably always likely to be the case. In addition, 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 the design and delivery of specific services, and community organisations often play a role in local service-delivery networks. The growth in local level networking has been the main means of increasing community participation, and has 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. As a result the 2001 health reforms have facilitated a partial version in the health system of the shift from 'government' towards 'governance' seen in other sectors and outlined earlier in this report (Newman, 2001).

3 Implications of the 2004 Legislative Changes for the Health System

Since the restructuring of the health sector was undertaken in 2001 and since the evaluation began, there have been important general legislative changes to public sector management with significant potential implications for the publicly-funded health sector; in particular, the State Sector Amendment (no. 2) Act and the Crown Entities Act, both of which were enacted in 2004. The former statute extended the broad state sector regime that had applied to the 'core' state sector such as central government departments and ministries to all state agencies and services, including, for the first time, DHBs and the rest of the publicly owned parts of the health system. The aims of the Act were to modernise leadership development in the state sector and extend its scope beyond the 'core' public service to include all Crown Entities, including DHBs and local government; to provide a statutory basis for the standards of integrity and conduct expected of all Crown Entities; and to formalise the State Services Commission's (SSC's) role to provide advice on the machinery of government across the whole of the state sector in order to encourage a cross-government culture and set of values. The SSC is now responsible for improving and assuring the capability and integrity of the DHBs. It is too soon to know what effect this responsibility will have in DHBs.

This legislation was accompanied by the Crown Entities Act (2004) which provides a unified governance structure for all Crown Entities designed to improve the quality of governance by applying generalisable principles, clarify roles and relationships between the relevant Minister, board and organisation, and increase the degree of rigour in the choice of organisational form and governance regime for each Crown Entity. The emphasis on articulating general principles is very much in the tradition of New Zealand public sector management of the late 1980s and early 1990s and contrasts with the more bespoke approach developed for the 2000 NZPHDA.

The Crown Entities Act defines three types of statutory Crown Entity: agents; autonomous Crown Entities; and independent Crown Entities, each of which faces different requirements in terms of policy directives from Ministers. In each case, Ministers can appoint or dismiss board members and define their terms of office. Agents are defined as those entities required to ‘give effect’ to Ministerial direction (i.e. implement government policy). Autonomous entities are required to ‘have regard’ to Ministerial direction and independent entities cannot be directed by Ministers as to how to discharge their statutory responsibilities. The implication is that the overarching principles of public sector management should themselves embody ‘fitness-for-purpose’ decisions; in this case, recognising that different forms of public accountability may be appropriate for different purposes.

Statutory Crown Entities of all types are required to produce an annual Statement of Intent (SOI) which is tabled in Parliament, though negotiated with the relevant Minister. Departmental chief executives report progress in achieving the outcomes set out in the SOI to Parliament. All Crown Entities can be directed to take a ‘whole of government’, collaborative approach to an aspect of their work.

It is important to note that DHBs were categorised as ‘agents’ in the 2004 legislation (unlike school boards of trustees) and thereby required to ‘give effect’ to Ministerial direction, indicating 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 for delivering the government’s objectives for the health care system. 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 Ministerial direction in relation to particular issues. Whereas this legislative change may not have large day-to-day significance, it makes it clear that, at least for the foreseeable future, the formal relationship between DHBs and the centre is strictly hierarchical. In the event that DHBs grow in capability and accumulate experience in managing in a supposedly decentralised system, they will not have the right to claim greater autonomy.

However, presumably the new legislation does not rule out individual DHBs being given greater decision making discretion and autonomy by the Minister of Health as a reward for a high standard of performance.

Following the 2004 legislation, DHBs are currently accountable to the Minister of Health through an annual Crown Funding Agreement (on the basis of which they receive their annual budget according to the population-based funding formula that takes account of variations in relative needs between DHBs) and District Annual Plan, and to Parliament through a Statement of Intent (SOI) and progress reports against the SOI, the same as the arrangements for central government departments. Since 2004, Boards can appear before Parliamentary Select Committees to report on their SOIs, if required. While this was initially a fraught process with misunderstandings on both sides, it appears to have settled down as MPs and boards have become more familiar with each other.

On the positive side, 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 should also improve the protection offered to board members in the event of major performance problems. Again, it is too soon to know if the legislation has contributed to reducing any tension and controversy in relationships between the centre and the DHBs.

A third piece of legislation, the Public Finance Amendment Act, also of 2004, is more directly in line with the intent of the earlier NZPHDA in that it is designed to encourage a greater emphasis on achieving policy 'outcomes' on the part of Crown Entities (as opposed to a focus simply on delivering required services) and to try to reduce the degree of fragmentation between entities and increase collaboration, both goals of the NZPHDA. The Act, which is essentially a re-write and up-dating of the original Public Finance Act of 1989, allows for more flexible Vote (i.e. appropriation) structures at national level to

allow greater cross-departmental/agency and cross-sectoral action on particular issues. It also changes departmental reporting requirements to include financial and non-financial information, and to include capability and outcome reporting as well as output reporting. Again, it is too soon to know whether this relatively recent piece of legislation will have an appreciable impact on behaviour and achievements in the public health system, including at DHB level, but it signals that this emphasis in the NZ PHDA has become generalised across the management of the public sector.

4 Discussion: Competing Frameworks of Accountability?

Clearly, New Zealand's health sector has become characterised by multiple types of accountability since 2001. Such multi-faceted accountability has been identified as necessary and beneficial by a number of international commentators on public policy and management (Rhodes 1997; Hood 1998), but also heightens the potential for complex, conflicting accountabilities.

In practice, the evaluation has shown that for the health sector as a whole, the two strongest 'logics of accountability' are those of hierarchies and networks. Networking mechanisms have flourished at the same time as pre-2001 hierarchical controls have been refined and maintained. Market mechanisms, though still present for many community-based health and disability support 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 hierarchy (accountability to central government) with some market relationships is a potential 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' did not appear to collide very frequently during the period of the evaluation as long as responsibility for service delivery was clearly devolved. This can be attributed to a fairly clear, if not absolute, distinction between central government's role as developer of policy, and the DHBs' roles as implementers under the NZPHDA. However, as the evaluation of the gradual process of devolution of funding and responsibility for specific services to DHBs showed, there was some conflict about which services should be devolved, in which sequence and at what pace.

Despite some conflict of view, there was also evidence through the evaluation that DHBs acknowledged the importance of central government leadership in setting the broad direction of travel, while central government staff acknowledged that DHBs are often in a better position to work out how to implement central government strategies in practice than the Ministry of Health. This suggests a complementarity between the role of governments in establishing the key policy objectives (a hierarchical approach), and local and regional networks becoming salient in working out the practicalities of working towards these objectives.

This apparently reasonably successful, if not uncontested, demarcation between policy design and implementation in the early years of the new system (2001-05) is noteworthy given that the overlap of, and tension between, these broad functions bedevils many broadly hierarchical health systems. However, it may simply be that DHBs were so focused on establishing their organisations in the early 2000s that they had too little time and energy to want to steer policy in different directions to those set out by central government. 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 was the existence of a significant gap between general policy frameworks and implementation detail widely identified by DHB staff and board members. This gap can perhaps be attributed to the success of the 1990s health sector reforms in achieving the objective of separating policy from operations, but in achieving this, central policymakers may have lost some of their capacity to understand the practical challenges of policy changes for those charged with implementing them. As a result, staff in DHBs generally asked for more detail from the Ministry of Health on how to implement national policy rather than less, even while sometimes complaining about the unwarranted degree of Ministry interference in other areas of DHB responsibility.

At the local level, the research identified a dynamic tension between hierarchical and collaborative approaches to contracting, resulting 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 with a single national purchasing organisation. The trick in the future will be to combine such contracts with national standards and expectations of efficiency and equity of access to services.

Despite wide support for more local contracting, non-government providers were concerned about what they perceived to be a plethora of expectations placed upon them by DHBs and the Ministry of Health. This is because, for NGOs, all four broad types of accountabilities discussed above are present and can cut across each other. NGO relationships with other providers may be simultaneously co-operative and competitive. NGOs operate in ‘collaboration’ with DHBs, the Ministry of Health and the Accident Compensation Corporation (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 service delivery.

5 Conclusions

The Government's objectives in 2000 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. A nationally directed and funded system has been given a stronger local identity and more local venues for decision making have been created. Accountability in New Zealand's publicly-funded health sector since the 2001 reforms has become more multi-faceted with a mix of hierarchical, network and market forms in play. As a result, governance is more complex and sometimes more opaque in comparison to the 1990s. The broader range of accountability criteria and relationships seem better to reflect the characteristics of publicly financed health services, in particular, their multiple objectives and the involvement of many interests in their steering and production. The DHB model is not an elegant design, but the current system acknowledges tensions between different types of accountability for the direction of health policy and the use of public resources. It also appears to be more popular with the public and with health professionals. For example, much of the heat of the debate about health care reform from the 1990s has dissipated. However, the 'realism' of the model does entail some risk of a system without strong internal challenge to the status quo and without consistent pressures to improve. For example, other parts of the evaluation have shown that the post-2001 system is no more efficient, and may even be less efficient, than its predecessor, though it is likely to be somewhat more equitable (Mays, Cumming and Tenbensen, 2007).

Despite the fact that the 2001 model is rooted more obviously in health sector realities, some governance and management difficulties have been encountered, particularly in defining the appropriate roles and relationship between the centre and the DHBs. Those working in DHBs perceived that they had little or no autonomy and were frustrated by the lack of real devolution, at least in the first four years of the new model. In addition, the elements in the new model designed to increase transparency, community engagement and a balanced consideration of issues (e.g. by requiring DHBs to have disability and primary care committees in addition to a hospital committee) have not been as effective as hoped.

The evaluation suggests that far from there being only one ‘correct’ way of governing and organising accountability for tax financed care, there is a variety of feasible approaches, each with its own pattern of strengths and weaknesses, but none pre-eminently superior on all criteria of performance. This indicates that the goal of public sector management should be to identify systems of governance, management and accountability that are ‘fit-for-purpose’ bearing in mind the particular features and dynamics of different public services, and the emphasis given to particular objectives at different periods. In certain situations, this approach may lead to hybrids of different traditions. Seen in this light, perhaps there was too much emphasis in the past on an overarching, generally applicable approach to public sector management in New Zealand and not sufficient recognition of the need to take explicit account of the unique features of different sectors. The 2004 package of state sector legislation, taken with the NZPHDA, attempts to reconcile this tension

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