Health Reforms 2001 Research Project

Report No. 3

DISTRICT HEALTH BOARD

STRATEGIC DECISION-MAKING

Tim Tenbensel

On Behalf of the Health Reforms 2001 Research Team

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Table of Contents

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 2001Research: 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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Research team members in August 2007 were:

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Executive Summary

Introduction

The creation of District Health Boards has been a key plank of the health reform process launched by the incoming Labour-led government in 2000. Created from the remnants of pre-existing organisations at the national level (the Health Funding Authority) and at the local level (the 23 Hospital and Health Services), DHBs were legislated as local level organisations with responsibilities for both the provision and purchasing of health services in their district, and for developing policy at the local level. This policy function of DHBs has been referred to within the health sector as strategic decision-making.

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

The organisational environment that DHBs find themselves in, 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. In addition, under the organisational design of New Zealand's publicly funded health sector 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 a productive rather than a destructive tension.

This analysis of the first three years of elected District Health Boards (November 2001-October 2004) sets out to answer the following broad questions:

1. Have DHBs adopted a strategic focus on population health goals?
2. How does strategic commitment to population health goals translate into policy change?
3. Has the tension between community preferences and central government requirements been problematic?
4. Do DHBs have sufficient autonomy to be effective strategic decision-makers?

Answers to these general questions are drawn from the analysis of key dimensions of strategic decision-making. These are:

- Formal Strategic Decision-making (including Health Needs Assessments, District Strategic Plans and District Annual Plans)
- Community and Stakeholder Consultation and Engagement
- Priority-setting
- Implementation of Government Strategies

These dimensions provide the basis of this report's structure.

Research methods comprised two rounds of interviews in 2002 and 2005 with: national stakeholders (including Ministers, Ministry officials, and representatives from national provider organisations); all DHB CEOs, Chairs, and Planning and Funding Managers and key informants from five case study DHBs, including NGOs and community representatives.

As such, the findings contained in this report are primarily based on the perceptions of participants in the health sector. In this report, much material is drawn from the five case study DHBs, which were selected to represent the range of DHB settings in New Zealand. The case studies vary in terms of size, urban-rural mix and the ethnic composition of their populations.

Main Findings

Formal Strategic Decision-making

The principal finding regarding formal strategic decision-making is that there is enormous variety in how DHBs have approached it. Initially the strategic planning requirements were very challenging for DHBs. However, over the three year study period more DHBs became proficient in their planning processes.

The requirement that DHBs engage in Health Needs Assessment (HNA) as part of their planning processes has been met with enthusiasm by DHBs. The main benefit of the HNA process has been its usefulness in sharpening the DHBs focus on population health. However, concerns remain about the capacity of smaller DHBs to gather relevant local information and the paucity of data on primary care utilisation.

The formal strategic planning processes - one year District Annual Plans (DAPs) and the five year District Strategic Plans (DSPs) - have been undertaken by DHBs with varying degrees of eagerness and proficiency. There has been considerable variation across the country in DHB perceptions of their planning requirements. Some found the formulation of DAPs useful whereas DSPs were difficult and problematic. Others reported exactly the opposite.

In some cases, the status of these documents as formal accountability documents requiring sign-off from the Ministry was difficult to balance with the need for these documents to be addressed to local constituencies. There was a strong perception from community representatives and stakeholders that there was little scope for contributing to DAPs and DSPs as these processes were primarily set up to meet the needs of the DHB organisation and the requirements of central government.

Overall, it is difficult to speak of DHBs having overall strategies that flow directly down to decision-making processes and resource allocation. However, it does appear that DHBs are able to plan and make progress in developing new approaches in specific service areas such as primary health care or cardiovascular services, and that these directions are generally consistent with the government's NZHS objectives.

Community and Stakeholder Involvement

Communities and stakeholders, particularly non-government providers, have been much more extensively involved in health sector decision-making processes than in the 1990s, and this is consistent with the government's intention to broaden input into the health sector.

DHBs have clearly recognised the statutory requirements for community involvement but there was significant variation in how this was implemented. Some DHBs made concerted efforts to gather community input, whereas others adopted a more minimalist approach.

If the focus is expanded from community involvement in formal consultation processes, a much more positive assessment of the role of community input is possible. A strong theme to emerge was the emphasis on community *engagement* or *involvement* as a more encompassing process than community consultation. Community engagement is based on relationship-building so that channels of two-way communication are established. As such, DHBs are better able to 'take the pulse' of their communities through the relationships that have been built.

Closer relationships are generally more likely in smaller DHBs, but these closer relationships can also promote expectations of a greater community role in decision-making that may be difficult for DHBs to meet.

In general, community representatives and non-government stakeholders were more interested in engagement with DHBs in order to shape service design and delivery, rather than in participating in consultation exercises feeding into planning documents. For their part, DHBs were also generally appreciative of community input into service design and delivery, and over time DHBs have put less effort into formal consultation exercises.

Among DHB respondents there was marked ambivalence as to whether or not communities had made a difference. The degree to which community input did make a difference to DHB decision-making was largely a reflection of the distinction between 'big picture' strategic planning and 'bite-sized' service issues. The clearest examples of community influence on decisions have been in relation to specific service design and delivery issues whereas examples of influence in strategic planning were thin on the ground.

Priority-setting

Because of the challenges in specifying causal links between health organisation decision-making and broader health outcomes, resource allocations (inputs) remain a powerful indicator of organisational priorities.

Explicit prioritisation of health services was a major theme of the 1990s health reforms and at the end of this decade the Health Funding Authority had developed a more formal framework for evaluating proposals for new spending (HFA 2000).
Priority-setting needs to be seen in the context of overall health policy direction pursued by government in the 2000s, most importantly the New Zealand Health Strategy and the Primary Health Care Strategy, which involve a broader shift in health system focus towards population health outcomes.

The willingness and capacity for DHBs to engage in formal, explicit priority-setting varied considerably across the country. Some of the case study DHBs had developed prioritisation frameworks but none were operational and none could point to sustained prioritisation exercises that drove the reallocation of funds.

The weight of historical resource allocations was the most significant constraint to priority-setting. DHBs have found it virtually impossible to disinvest from existing services and know that any attempt to do so would invite community opposition and/or a central government veto.

The capacity to make new investments is largely dependent on the availability of discretionary funds. Central government is the biggest influence on the degree of DHB discretionary funds either through targeted funding or through redistribution between DHBs which has been facilitated by the Population Based Funding Formula (PBFF).

At the margins of spending, many DHBs have developed formal prioritisation processes that support decision-making processes when new money is available. Those DHBs that have been net beneficiaries of PBFF are more likely to have some capacity to apply such processes. However, due to the very small sums of money involved, they are still faced with the dilemma of spreading new funds over multiple projects or developing a 'critical mass' of funds to do one thing properly.

This priority-setting at the margin provides the only tangible link between overall strategic planning and more fine-grained prioritisation processes, which are otherwise only loosely coupled.

Implementation of Government Strategies

There is substantial agreement within the New Zealand sector regarding the broad objectives of the health strategies. Getting from broad support to concrete implementation has been identified throughout the sector as the most central concern.

The NZPHDA clearly locates responsibility for implementation of government strategies at the local level. While DHBs and the local health sectors appreciated the opportunity to devise their own approaches and solutions, they also often expressed frustration with what they saw at times as a lack of practical guidance and sheer scope and scale of innovation they were expected to foster.

Government strategies were certainly important in terms of board time and energy, but due to the difficulty of reallocating resources it was sometimes difficult for DHBs themselves to see how this translated into practice. Generally, the strategies regarded as more effective were those linked to new funding streams such as the PHCS. DHBs

sometimes struggled to accept responsibility for new central government strategies and requirements when these did not come with additional funding.

Without exception, the strategies are reflective of the directions that opinion leaders and key stakeholders in various parts of the health sector see as necessary. However, the capacity of existing organisations to meet these aspirations in the short-term is constrained by factors such as organisational boundaries, funding and occupational work practices. The danger of setting expectations too high was a constant theme in interviews throughout the sector.

There was also widespread concern about the degree of integration between different strategies, particularly the PHCS, the Disability Strategy and the Health of Older Peoples Strategy.

Assessment

Have DHBs adopted a strategic focus on population health goals?

DHBs have clearly moved towards a strategic focus on population health goals. There is no doubt that there has been a significant cultural shift in the health sector towards an understanding of the importance of serving populations. 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. There is significant support within the health sector for the broad vision of the New Zealand Health Strategy.

How does strategic level commitment to population health goals translate into policy change?

Strategic decision-making has proven useful for DHBs to focus on the drivers of population health. However, DHB organisations do not have many levers of change readily at their disposal, and those working at the local level are only all too aware of the gap between expectations and capacity.

Has the tension between community preferences and central government requirements been problematic?

The tension at the heart of DHB's organisational environment has, on balance, has been less problematic than many observers expected. The national strategic framework has provided DHBs with a clear substantive focus that may not have otherwise been achieved. Communities have been more interested in having input into service design than into district strategic planning. As such the actual areas of overlap between central government and local community influence have been quite small.

Do DHBs have sufficient autonomy to be effective strategic decision-makers?

When it comes to more concrete decision-making, the autonomy of DHBs remains relatively limited, although it has been increasing slowly. In practice, there is not that much scope for DHBs to make decisions that are inconsistent with national policy settings, or significant departures from historical patterns of resource allocation.

Glossary

Sources and their abbreviations

A:	Case Study A
B:	Case Study B
BMS:	Board Member Survey Final Report
C:	Case Study C
CEOS:	CEO Survey
Ch:	Chairs
D:	Case Study D
DS:	Disability Stakeholder Report
E:	Case Study E
EIR:	Case Study E Interim Report
EM:	Case Study E
IR:	Interim Report
NS:	National Stakeholders

1 Introduction

District Health Boards were established to 'provide for the effective co-ordination of the planning, provision and evaluation of health services between the public, private and non-government sectors' (Labour Party, 1999). Created from the remnants of pre-existing organisations at the national level (the Health Funding Authority) and at the local level (the 23 Hospital and Health Services), DHBs were legislated as local level organisations with responsibilities for both the provision and purchasing of health services in their district, and for developing policy at the local level. This policy function of DHBs has been referred to within the health sector as strategic decision-making.

1.1 Context for DHB Strategic Decision-making

The impetus for DHB strategic decision-making is driven by an array of factors. The most important of these is the substantive health policy agenda of governments since 2000. The overarching policy priority since the beginning of the decade has been the improvement of population health outcomes embodied in the New Zealand Health Strategy.

The strategic decision-making environment has also been shaped by the past two decades of public sector reform in New Zealand that have stressed the formal accountability of public sector agencies. Since the late 1990s there has been a move away from output-based accountability towards outcome and process-based accountability (Gregory 2003).

A third key factor is the re-emergence of community participation as an important facet of health decision-making. As the dominant party in the new coalition, the Labour Party clearly established community participation as a key point of difference between it and the National Party-led administrations of the 1990s.

1.2 Prospects and Constraints for Strategic Decision-making in the Publicly Funded Health Sector

International scholarship on the health sector and previous New Zealand experience indicate that there are substantial challenges to the achievement of strategic decision-making in health sector organisations. Control over health system decision-making is enormously difficult to achieve compared to many other areas of endeavour (Glouberman & Mintzberg 2001).

Health systems in higher income countries such as New Zealand's have been predominantly shaped by the organisational and professional needs of providers of health services, particularly medical professionals. This often means that the efforts of governments to steer health policy, and the efforts of public sector health organisations to reallocate health resources can meet significant and often successful resistance when this involves reducing allocations to medical and surgical services.

As literature in public policy and organisational studies has demonstrated, any study of explicit decision-making processes doesn't in itself provide a full picture of how organisational policy is formed. It needs to be considered in the broader context of factors that shape organisational and health sector direction. 'Non-decision-making (Bachrach & Baratz 1969; Crenson 1971) can sometimes be a more significant impact on the strategic direction of policy than explicit decisions.

In the New Zealand context, the capacity of DHBs to set and follow an explicit organisational direction is also circumscribed factors which are largely beyond their control, such as international labour markets for health care workers.

1.3 Specific DHB Accountability Requirements

District Health Boards are the product of two potentially disparate and conflicting rationales. They are accountable to the Minister of Health at the same time as being accountable to their local electorates, and they are required to implement central government policy and to be responsive to local needs.

In a 2000 Memorandum to Cabinet, the Minister of Health described the accountability requirements as aiming 'to obtain the best DHB performance by creating an effective incentive structure, aligning the goals of the Board with those of the Government, and where appropriate controlling DHB activities' (Office of the Minister of Health, 2000: 2).

This tension between their role as implementers of national policy and organs of local responsiveness makes for a rather unusual organisational environment. The potential advantages are that this accountability structure is the most appropriate for advancing substantive national health policies while recognising the inherently local nature of health service delivery. On the other hand, such an arrangement could be a recipe for buck-passing and arguments over which level of organisation is responsible for what.

A central question underlying this strategic decision-making report, therefore, is whether the inevitable tension created by this structure of accountability is a productive or a destructive tension.

1.4 Methodology

Data for the analysis of DHB strategic decision-making has been drawn from a range of sub-projects of the Health Reforms 2001 research. These sub-projects included:

- Interviews with national and government stakeholders
- Two interviews with CEOs of DHBs
- Two interviews with Chairs of DHBs
- Two postal surveys of Board members
- Case studies in five DHBs

Full details of the research methodology used, and a preliminary compilation of data relating to governance, can be found in the *Interim Report of the Health Reforms 2001 Research Project* (Cumming et al 2003). Reports on the above research sub-projects will be available separately.

While all the sub-project reports have been drawn upon, this report has made most extensive use of case study reports. The majority of case study interviewees are either board members or DHB employees. While this might be expected to paint DHBs in the most favourable light possible, many DHB informants were in fact quite frank in discussing aspects of strategic decision-making where there was room for improvement.

Case study reports also drew from interviews with local stakeholders including non-government providers and community representatives. The perceptions of these informants often matched those of DHB informants, but also differed regarding a number of topics such as the adequacy of processes for community engagement and involvement.

Quotes from interviews with all types of informants are used extensively in this report. Wherever possible, quotes are used to illustrate the range of perceptions of particular topics and issues. With the exception of the Board Member survey, it is not generally possible to make definitive statements about the relative prevalence of differing viewpoints.

2 Formal Strategic Decision-making

Under the New Zealand Public Health and Disability Act (NZPHDA), the Minister of Health and the Minister for Disability Issues are responsible for the over-arching New Zealand Health Strategy (NZHS) and New Zealand Disability Strategy (NZDS) to provide the framework for the Government's overall health sector direction in improving the health of people and communities and for disability support services (s. 8). Health Needs Assessments (HNAs) are to be used to inform District Strategic Plans (DSPs) (s. 38).

The DSP states the objectives of the DHB for the five to ten year period from the time of determination, and is to be made publicly available, as are any amendments. These plans are to be reviewed at least once every three years. DHBs are also required to produce District Annual Plans (DAPs) each year in order to provide a more short-term focus to strategic decision-making.

The tension between local community and central government audiences is built into the strategic planning process. The Minister of Health's advice to Cabinet in 2000 contained the following statement:

> *It is recommended that each of the documents is provided in a form, and within timeframes set out by the Minister of Health, to promote transparency and consistency, and facilitate comparison and review across DHBs. It is also recommended that these documents be widely and freely available to the public.'* (Office of the Minister of Health, 2000: 8).

2.1 Health Needs Assessment

A key component of formal strategic planning that has been stipulated in the NZPHDA is the conduct of Health Needs Assessments. Health needs assessment is defined as 'the assessment of the population's capacity to benefit from healthcare services prioritised according to effectiveness, including cost-effectiveness, and funded within available resource' (Coster 2000). Initial HNAs were conducted in 2001. The following extract is taken from the Interim Report (IR: 48).

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

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

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

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

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

Interview data from the case study DHBs in 2002 and 2004 painted a picture in line with Coster's findings. Key informants at the national level noted the importance of the HNAs to the strategic planning processes that DHBs must undertake. That is, the DHBs:

> *'…take the needs assessment, put that together with resourcing, availability, currency and capacity to move things on the edges and then work through a strategic planning process with their local communities and then come back to the Minister for sign off on this is where we want to go in the next three to five years'* (KII 7, R2).

Generally, the HNA requirement was viewed very positively by DHB informants. Over half of the CEOs surveyed in 2004 (10 out of 19) commented that they were satisfied with the first HNA and the DHB's ability to use it effectively in the strategic planning process (CEOS: 11)

Many case-study DHB respondents concurred:

> *'We believe the whole concept around HNAs and DSPs has been very useful. In fact we have found that [its] a really good process for [identifying the priorities]… A lot of it's driven the focus that we've taken on inequalities in [localities P & Q], emphasising Pacific children more…'* (B: 31)

The larger case study DHBs dedicated a significant level of resource to the compilation of the HNA document and the HNA process was seen to provide a useful way of linking national strategies, particularly the NZHS, with local needs. Given the 13 population health objectives identified by the NZHS, the process of HNA enabled DHBs to identify which of these should be given most priority in their planning processes.

A number of the case study DHBs reported how the HNAs specifically fed into their planning processes. Case Study C's top four priority areas were based on their HNA, while Case Study E used the HNA to identify diabetes and cardiovascular disease as top priorities. Asthma, which was not included in the NZHS population health objectives, was given high priority in Case Study D, partly as a consequence of the HNA (D: 39).

The organisational capacity to collate HNA data varied according to size. The three larger urban case study sites all conducted their own HNAs. Generally, while these DHBs regarded the exercise as very useful, they were aware of the limitations of the initial documents they produced. One case study Board regarded the initial HNA as work in progress (A: 28), while another saw the main value in providing useful baseline information for future comparisons (E:25).

One national stakeholder organisation respondent questioned whether DHBs are sufficiently skilled at HNAs.

> *'The skills to do good community assessment and forecasting of need are very specialised, and in New Zealand there's probably only two or three health demographers, for example, that you'd say are really top notch and yet each DHB is having to try and do that.... Health forecasting needs to be strongly and centrally resourced so that everyone's got the best information available to do their planning and respond to it and that's probably something that the Ministry logically can facilitate. DHBNZ may well do it, [which is] what's tending to happen I think.* (NS: 20)'

In only one case study site (Case Study D) did there appear to be a marked level of DHB dissatisfaction with the initial HNA process. As a smaller DHB that contracted the HNA work to the Wellington School of Medicine and Health Sciences, respondents from this DHB felt that the process was driven too much by external priorities and timeframes.

Some CEOs expressed reservations that the process was too cumbersome and that the quality of information, particularly in primary care, was not adequate for planning (CEO: 11).

Case study DHBs also identified the lack of quality primary care and general practice utilisation data as a significant limitation. Case Study D respondents saw the PHO structure as a way of dealing with this data deficiency as PHO information systems on utilisation and ethnicity in primary care would be used in conjunction with the DHB's data on secondary care in future.

Another perceived benefit of the HNA process was that it helped to facilitate links and dialogue between the DHB and other local organisations, including local councils. Case Study A, for example, has used the HNA and the other strategic planning documents as a means of aligning with the city council long-term community plan (A: 29).

2.2 District Plans

The NZPHD Act mandates two planning processes – the one year District Annual Plan (DAP) and the 5 year District Strategic Plan (DSP). These planning requirements exist alongside broader DHB accountability requirements that are relevant to DHB's Crown Entity status including the Statement of Intent (SOI), the Crown Funding Agreement (CFA) and the Annual Report.

Results from the two Board Member surveys indicated that most respondents felt that their Board spent enough time on policy and strategic planning matters and that this proportion increased between the two surveys from 61% to 68%. In both surveys, approximately half the respondents thought that the Board provided a clear vision for local health development.

Some concerns were expressed about the formalisation of strategic planning. Another CEO commented:

> *'You spend a lot of time and opportunity on planning. And unfortunately it consumes what I call the real strategic thinking and insight. If you can somehow stop the planning from taking over, you know, the huge routine process, this bureaucracy, but short on critical insight and getting a bit of focus on the three or four things that might make a difference.'* (CEOS: 12)

Among the case study sites there was considerable variety of perception of the formal strategic planning process. DSPs were regarded by many as a cornerstone of DHB activity. According to one CEO:

> *'...the strategic plan has certainly been a fundamental document for us that we've lived by...there has been a lot of really good work and we are trying to roll out the investment strategy around that now.'* (CEOS: 11)

One case study DHB informant was more equivocal:

> *'..the whole strategic planning process really is not robust, yet. ...The DSP... still to my way of thinking doesn't impact sufficiently on the behaviour... it doesn't yet determine our behaviour and our decisions. But the translation of the health needs [assessment] into our DAP is becoming more transparent.'* (B: 32)

Another DHB chair concurred that the DSP was problematic but that the DAP played a central role in decision-making:

> *'We're operating in an environment where new initiatives are not possible and where we are focusing very much on day-to-day issues and how we can get control over them. I don't know whether the time and effort that goes into the Strategic Plan gives a payback. If anything it simply raises expectations for people we cannot possibly meet. The District Annual Plan is a different issue entirely, the in-depth analysis required for that is very helpful.'* (Ch: 9)

Yet for other DHBs, it was the DAP that created more headaches. The DAP process contains an inbuilt tension between satisfying the general requirements of the Ministry and the specific requirements of the DHB. Balancing these somewhat differing requirements proved difficult for many DHBs in the early years. Many DHB respondents felt that the DAP process in particular was too constrained by Ministry requirements. One respondent regarded the DAP as the weak point in the planning process because *'even sometimes the words are dictated by the Ministry'* (B: 32).

From the Ministry's standpoint, the reason for monitoring and providing standards for the DAPs was to see if there were signals indicating a mind-shift from a hospital to a population health perspective. One key informant noted some DHBs' plans showed this, but not all.

A number of case study boards had initial problems getting their first DAPs signed off by the Ministry of Health. In the Interim Report there had been some concern within DHBs that DAPs were ineffective and would simply 'gather dust' due to the time it took for the DAPs to pass muster with the Ministry. The delays in Ministry approval tended to be due to concerns over how the DHBs were managing financially, particularly if they were in deficit, rather than being driven by concerns over the content of the strategic direction.

However, this source of frustration became less of an issue for both DHBs and the Ministry in subsequent years, and our research indicates a growing level of comfort with the process and sophistication of the product.

In another board, the DAP was seen as more problematic because the DAP process had been beset by internal board politics. One informant from this Board claimed that *'we have struggled to make it a useful document'* (B: 32).

Nevertheless, many DHBs became more adept over time at writing the plan for both the Ministry and their own organisation. According to one CEO:

> *'We took the view that we were writing the DAP for our own organisation, but that we would be sharing it with the Ministry. Now that mindset becomes important because then you are not doing it just to satisfy Ministry requirements; you are doing it so that you can run your own business.'* (CEOS: 12).

Some of the case study DHBs had used the planning documents as the basis for regular monitoring of progress. Case Study D placed a great deal of ongoing emphasis on the DAP, treating it as an effective bridge between short and long term planning timeframes. In this district, DAPs were regarded as more than a one year document, and the Board had instigated a process of reporting to the Board about every two months against the DAP.

3 Community and Stakeholder Consultation and Engagement

The Labour Party's health policy statement in the 1999 election campaign identified community involvement in decision-making as one of five guiding principles for the health system (1999: 2). The New Zealand Public Health and Disability Act identified majority elected membership on DHBs and community consultation in formal planning processes as the key mechanisms for community involvement. The impact of elected board members is considered in the Governance Report, and this report focuses on other avenues of community input into strategic decision-making.

Over the course of the research project it became clear that practices of community consultation and engagement cover a wide ambit ranging from formal consultation with members of the public on strategic planning documents to informal network-building with non-government providers and consumer representatives about health service planning. As such, the ambit of this discussion of community consultation goes beyond what is specified in the Act.

3.1 Who is Consulted?

In most policy areas in which involving the community is seen as important, there are multiple and sometimes conflicting ideas of just who and what the 'community' or the 'public' is (Hogg 1999; Taylor 2003). A variety of meanings of community are present in the activities of DHBs. The community, as local ratepayers, is involved firstly in the election of Board members, Board meetings themselves are also open to members of the public. More generally in the New Zealand health context, the term community has been used variously to refer to consumers of health services, non-DHB providers, stakeholder networks of providers, local government, grass-roots community organisations, and the 'uninterested' (i.e. those with a general rather than a specific interest) general public.

Some DHBs recognised the need for quite different approaches to consulting stakeholder, consumers and the wider community respectively. One case study DHB made a clear distinction between general community input into strategic planning, and stakeholder (including consumer) input into service planning (B: 38-40). But in one case-study DHB, there was no distinction made between stakeholders and the wider community. In this district, consultation was seen as a small part of stakeholder participation (A: 29). In other case study DHBs informants saw a clear tension between input from community organisations and provider organisations. There was some criticism of provider organisations cutting community organisations out: *'it seems to be a fear of allowing community organisations ... they want to do it themselves.'* (D: 50)

In some case study districts, DHBs were able to tap into existing grass-roots community networks that were the source of a different type of input to that provided by provider and consumer organisations focused on their own segment of the health sector.

Local *mana whenua* and other Māori community groups were often consulted specifically and many DHBs had set up specific mechanisms for consultation with Māori. Runanga and other iwi structures were particularly important in the two smaller case study districts, both of which had relatively a high proportion of Māori within the district. One DHB had a permanent *mana whenua* group advising the Board (C: 19). In Case Study D, the CEO meets regularly with both runanga in the district (D: 49).

Two of the larger urban case study DHBs have had local community health advocacy organisations operating within their districts. These are organisations that attempt to facilitate linkages between people and organisations that have an interest in local health issues. In both these DHBs, such organisations were present only in particular sub-districts. This meant that there was considerable variety in the level and nature of community engagement *within* districts as well as between them.

3.2 What are They Consulted About?

3.2.1 Consultation and strategic planning

Community involvement in strategic planning took various forms including board and committee meetings being open to the public, formal consultation processes, presentations at board and committee meetings, public forums held prior to board meetings and holding board meetings in different venues within the district rather than at organisational headquarters. Most case study boards reported bringing key stakeholders such as non-government providers and clinical decision-makers into strategic decision-making processes.

In one case study DHB, the annual planning process brings stakeholders together at the end of the year with the aim of the DHB gaining feedback on its performance and to give stakeholders the opportunity to raise issues relating to the next round of strategic planning (A: 30). However, in another case study Board, there was no significant consultation on the DAP because of a board perception that the DHB population had been "consulted-out" at the time (B: 38). There were also significant barriers to community engagement in planning processes that were due to the formal nature of planning documents and the inexperience of DHBs in producing them. According to one DHB respondent: *"the biggest thing that we got back [from consultation] was [that] the document [DSP] is not very easy to read"* (EIR: 28).

The research indicates significant variation over time and between districts in levels of community and stakeholder engagement in strategic decision-making. In at least two case-study boards the level of consultation could be described as minimal. In terms of the expectations of the model, this finding is cause for some concern. However, the lukewarm level of consultation regarding strategic decision-making should be seen in a wider context. The expectation that strategic planning documents and processes provide a platform for accountability to central government and to the local community, while engaging provider stakeholders places considerable and conflicting demands on DHBs.

3.2.2 Engagement in service design and delivery

In addition to consultation on strategic planning, many of the case study DHBs engaged in specific consultation exercises relating to particular areas of service provision. Local communities were often sometimes substantially involved in the processes for establishing PHOs in the district. For example, community representatives and activists successfully pushed for the creation of a small PHO in the district of Case Study C, while in Case Study E there was a concerted push to influence the nature of community representation on the board of a particular PHO. Mental health, maternity services and primary care were service areas commonly mentioned in which DHBs engaged with providers and community representative. Case Study B convened Service Advisory Groups comprising of community representatives, providers and DHB staff.

Also prominent in the case study data was reference to issues in which there was the possibility of community opposition to courses of action proposed by DHBs. In one DHB, there are separate consultation processes specific to particular issues, significant service plans and strategic plans. As a general rule, specific consultation processes are employed when there are any substantial changes in health services, (C: 22). Land sales by Case Study A DHB and the closure of a facility in Case Study C were given as examples of this type of community input.

3.3 How are They Consulted?

In both the 2002 and 2004 board surveys, approximately 70% of respondents agreed or strongly agreed that 'the Board had established procedures for seeking community input'. However, interviews with Chairs, CEOs and other sector participants revealed an enormous variety of ways in which DHBs undertook consultation.

The striking finding is the highly localised approaches adopted, designed for the particular circumstances and philosophy of each DHB. Some had extensive and sophisticated communication strategies, others relied on working with relevant interest groups on specific planning issues. Some saw community engagement as involving the setting and managing of expectations. In general, community engagement strategies were two-way, with a strong information/public relations component as well as mechanisms for feedback.

In the early days of the DHB model, when DHBs were seeking input into DSPs, many boards organised public consultation meetings throughout the district. In one case study DHB, the whole Board attended these meetings (E: 26) while in another over half the Board attended (B: 38). The level of interest in such meetings varied considerably, but in both these DHBs the results were collated and fed back to participants. One of these DHBs also sought written submissions.

There was substantial variety between case study DHBs regarding the use of Board Advisory Committees as a mechanism for community input. One smaller case study DHB was characterised by significant community input into CPHAC and HAC. The Advisory committee meetings were seen as a forum for engaging with both the community and the sector managers. One informant referred to the membership as: '*critical; if you have got good community representation, it gives a different perspective'* (D: 47). In other DHBs, community input at governance level was restricted to making presentations to the board and committees. Some CEOs were of the view that community consultation was an inappropriate role for Advisory Committees (CEO: 13).

Some DHBs developed formal framework documents for community consultation. However, there was little indication that these frameworks were influential. For example, one case-study DHB drew up a Community Engagement Strategy in mid-2003, but according to one community respondent *'nothing much has come from it because there is no one driving it'* (E:31).

However, a focus on formal mechanisms of consultation would not provide a full picture of community input into DHB processes. A common theme to emerge was the emphasis on community *engagement* or *involvement* as a more encompassing process than community consultation. A number of case study DHB informants noted a shift in the style of interaction with communities from one of holding formal meetings and inviting public attendance to a style of meeting sectors of the community in their own settings and environment. According to one DHB informant the public meetings did not lead to much feedback but there was a lot when the consultation was done by approaching particular groups

> *'... the Board actually has in its agenda to revisit the various marae and communities throughout the district…. So the Board goes out onto the marae as well as the community and have their meetings there as well as being open here'* (D: 49).

Engagement was seen to involve building longer-term, trusting relationships, typically through ongoing face-to-face contact and maturing conversations (A: 39). Rather than being initiated when there is a project, it was a matter of being 'out there' listening to them all the time so when projects come up, you already know what people are saying and who to go to ask about different matters (D: 48)

Formal consultation processes were still common, but there was a growing recognition from a range of participants that the formal consultation mechanisms were primarily aimed at serving the needs of the organisation. DHBs were required to meet their accountability requirements to the Ministry and these needs drove the agenda of the strategic planning consultation processes.

3.4 Did Community Input Make a Difference?

Many Board Chairs regarded community input and consultation as having a significant effect on decision-making.

> *'There is no doubt that it helped identify key aspects of our services...the community advocacy was very strong and we were able to talk about how we could get around some constraints, talk with the Ministry of Health and get some concessions, because of that community advocacy.'* (Ch: 9)

However, other Chairs saw little scope for the public to have much effect at all on DHB decisions, claiming that the most important parameters were set nationally.

> *'We are the most prescribed industry on the country. It's very detailed, very prescribed and the [consultation] process takes up a huge amount of management time'*. (Ch: 9*)*

In the 2004 board member survey, a slight majority (53%) agreed or strongly agreed that community input made a difference to decision-making (BMS: 47). This indicates that a significant minority of board members, having identified that their Board had procedures in place for community consultation, did not see these processes as having a significant influence on decision-making.

This ambivalence over whether community participation made a difference was also reflected in case study interview material from 2002 and 2004. Opinion was divided about whether community interaction made any difference to the Board and organisation. A number of case study respondents referred to the 'challenge' of integrating community input.

> *'it was not always easy to listen to issues ... and then make it happen as people back in the office think they know what's best for everyone'* (D: 48).

One case study informant commented that there had been at least three or four occasions over the recent past where the Board had specifically modified decisions or thought about things directly because they had received feedback from the community and members of their advisory committees or representatives (D: 49)

One of the clearest examples of community input significantly shaping DHB decision-making occurred in Case Study C where one informant ventured that a particular PHO would probably not have been established if there had not been strong community advocacy. The strength of community opinion compelled the Board to find ways around the constraints of size, working with the Ministry to find a way of proceeding (C: 24). Another board changed its Strategic Plan to incorporate goals from the Mental Health Blueprint as a response to input from non-governmental mental health providers (E: 28).

Most of the examples of community and stakeholder input influencing decision-making related to specific service issues. An informant from the DHB that instituted Service Advisory Groups commented that these worked well and had an impact on policy (B: 40). However, comments indicating that community input was a significant factor shaping strategic planning were notably absent.

Incorporating public input in DHB decision-making can be straightforward when there are no significant differences of opinion within the community. There were occasions when Boards sought community input on contentious issues, only to find that the differences were replicated within the local community. One board engaged in consultation on the future of maternity services, but these processes did not produce a clear picture of what the community wanted. As one respondent commented: *'unfortunately for us the results were not decisive so it headed back to us'* (E: 31).

The requirement for community consultation could also make a difference to decision-making processes in DHBs. Some DHB informants saw the value of community consultation and engagement as a 'reality check', so that Boards did not go off in directions that would meet community resistance. Others emphasised the consultation's function of educating the wider community, particularly when community views differed from Board policies.

> *'If you do a good facilitative process you can actually get quite a good result out of ...dealing with those conflicting ideas' (C: 23).*

3.5 Community, Māori and Stakeholder Perceptions of Consultation

Community representatives generally had higher expectations of consultation and engagement than did those within DHBs. In some cases there was clear enthusiasm regarding the capacity of community to influence decision-making. A community representative spoke about the direct line of communication that allowed her on one occasion to initiate a review of discharge plans after an incident of poor discharge planning. One praised the consultation process that allowed input to modify the DSP (D: 48).

Some tended to regard DHB consultation practices as rudimentary, but gradually improving.

> *'We started off with the legislation for it, the requirements and things like that. And people said 'yes, we've got to do this' but I got the impression that a lot of people didn't really think it was worth doing that it was actually a bit of a nuisance: a kind of 'add on' thing. I think now that some people at least are starting to realise that is a really useful thing to do. And it's not that hard, and it won't upset everything; and that it will actually help things gel a little bit more. But I still think that in most cases it's just lip-service.'* (E: 31)

Others saw the ideal role of communities in Advisory Committees as being far more extensive than envisaged by the NZPHDA:

> *'I would like to see them with one Board member as liaison and the rest community representatives so they are community committees'* (D: 50).

Māori respondents also often had quite different perceptions of the adequacy of consultation, engagement and partnership. In one case study DHB in which DHB informants reported good relationships with *mana whenua,* iwi respondents objected that the Board takes *'advice rather than direction'* (C: 19) and that the Board often consults *mana whenua* late in the decision-making process. Another respondent in a different district echoed this sentiment and that consultation with Māori regarding the DAP was of little purpose other than developing networks (EM: 14).

Non-government providers viewed the parameters of strategic planning as set by DHB organisational needs. One local NGO respondent, commenting on involvement in the 2004 DAP process commented *'the framework was pretty much a given in terms of we could only discuss it in these quite tight parameters'* (E: 28). According to one national stakeholder:

> *'...they tend to use all of these strategies I think to determine their own strategic plans and their own business plan' but without consulting widely. If there was consultation, it tended to be an invitation to comment on a Draft Strategic Plan rather than being given the opportunity for earlier input'* (NS: 20).

One respondent from the mental health sector commented generally that local stakeholder networks were working well, but raised questions about the capacity of DHBs to respond to ideas from beyond the DHB.

> *'Ideas and issues come up from the local stakeholder networks but then they're dissipated and they don't go anywhere because you've got a whole lot (of) DHB's interests in there trying to have their ten cents worth and get investment in acute care and all that, so it tends to get lost'* (EM: 15)

Some informants were doubtful that the DHB model had heralded in more consultation. One NGO considered DHBs were not consulting much, and that this had not changed or improved over time. One national stakeholder respondent claimed that *'in the earlier days of the DHB I think it was more participatory than it is now'* (NS: 20). Nevertheless, consultation with stakeholders was seen to vary significantly across DHBs. A survey of members of a disability advocacy organisation from throughout the country indicated *'there are some DHBs whom providers think they are doing are grand job and there are other DHBs that are really being not that consultative'* (NS: 21). Provider organisations that had dealings with the range of case study DHBs also noted significant variety. Two of the urban case study DHBs were seen as more problematic, mainly due to historical organisational problems that predated the DHB model.

3.6 General Comments

There is a real issue of scale at work with community engagement. DHBs serving smaller populations, perhaps unsurprisingly, found it easier to connect with their communities and be influenced by them. Larger case study DHBs had, by necessity, a greater degree of formality in their planning processes, and there was generally less 'traction' from formal consultation processes. However, the larger DHBs often also showed considerably more flexibility in other aspects of community engagement, particularly in relation to service delivery. Within larger DHBs, community engagement varied significantly *within* the district, according to the presence or absence of established grassroots organisations at the local level.

Clearly, community participation in formal, strategic, 'big picture' planning processes has become relatively less significant to the DHB model as it has evolved while community involvement in 'bite-sized' service planning issues has become more significant. Local communities tend to be more focused on influencing what happens *within* a service than they are on shaping the pattern of distribution *between* services. This focus on service design and delivery possibly indicates that communities are most interested in shaping things that they feel they understand and have some control over, and less interested in filling roles prescribed for them by legislation and government agencies.

4 Prioritisation

Prioritisation of health services was a major theme of the 1990s health reforms and this was reflected in the structural feature of separating the functions of purchasing and provision of health services. Within this structure, purchasing agencies had clear responsibility for planning the best use of their available resources. The purchasing agencies were amalgamated in 1998 to form the Health Funding Authority. In its short existence, the HFA devoted considerable attention to developing a framework for priority-setting. By 2000, the HFA had developed a prioritisation framework that could be applied to proposals for new funding.

With the dismantling of the HFA and the removal of the purchaser-provider split, many in the sector argued that the impetus for developing priority-setting would be lost as the expertise that had been gathered within the HFA would be scattered. District Health Boards, though given some responsibility for prioritisation, might have been expected to find explicit priority-setting difficult.

In 2002 the Ministry of Health recognised the issue and set up a joint Ministry-DHB sector working group to look at how the HFA framework could be adapted as a decision support tool at DHB level. This resulted in the production of a prioritisation toolkit for DHBs - *The Best Use of Available Resources: An Approach to Prioritisation*. This document incorporated and refined much of the conceptual framework developed by the HFA, translating it into a decision support tool tailored specifically for the DHB environment.

In the DHB environment, prioritisation needs to be seen in the context of overall health policy since 2001, and most importantly in the light of the NZHS and the PHCS.

4.1 What did Priority-setting Involve?

Interviews with DHB CEOs revealed that all DHBs claimed to engage in some sort of priority-setting, and that there was significant variation in what DHBs understood priority-setting to be.

Most DHBs saw prioritisation as applying to new money. This finding was based on interviews conducted in 2002, and has been confirmed by separate research undertaken by the National Health Committee in 2003 and 2004.

> *"Particularly revealing in this regard was that most people interviewed initially assumed that questions about "prioritisation" referred to prioritising the allocation of new resources, rather than reallocating existing resources. Several interviewees, especially those outside the analytical realm, initially made comments to the effect that "we don't prioritise here, since we don't have any new money coming in."* (NHC, 2004a: 9)

Beyond this broad commonality, case-study interviews indicated a wide spectrum of interpretations of prioritisation. At one end of the spectrum, a number of DHBs were proactive in establishing formal prioritisation frameworks to assess a large range of services. This approach to prioritisation required a significant commitment of organisational resources.

In early 2002, Case Study E attempted to engage in an exercise of explicit priority-setting in order to identify candidates for disinvestment from existing contracts. The consideration of proposals for new spending was not part of this particular exercise. When across-the-board scoring and ranking systems were used by DHBs they were characterised as *'quick and dirty'* (EIR: 29) and *'very clunky'* (D: 52).

Case Study D adopted an across-the-board approach (each service was given a score out of 200), and services consistent with the NZHS were ranked highest. According to a number of respondents, the ranking system was not particularly influential in allocating new funding, as such decisions were based on *'gut feel that this service or that one is slightly more important but perhaps the following year the other high priority areas are chosen as they are all important'* (D: 53).

At the other end of the spectrum, HNAs and central government policy provided DHBs with a definition of their 'priorities' and priority-setting simply meant building these priorities into planning processes. Case Study C saw HNA as a process for identifying priorities but made no mention of any identifiable prioritisation framework.

In between these poles was an approach that involved identifying a relatively small number of services that were candidates for increased investment and developing a process for deciding between these candidates. This variant seems to be the most consistent with the Ministry/DHBNZ model. These prioritisation frameworks were tools to assist boards in their strategic planning. According to one chair:

> *'Each year we have sought to prioritise a list of initiatives using a tool that was approved by the Board with careful weightings of different factors of value for money, the evidence base for those initiatives and impact on reducing disparities, etc. ... It's not a mechanical thing in that the Board will still make its own political judgement about what it will fund...but it's been a vary important guide.'* (Ch 10)

A fourth approach to prioritisation concentrated upon reallocating resources within particular service areas. Two DHBs, for example, identified reallocation of resources within cardiovascular services (A: 31; B: 35).

4.2 Restrictions on Prioritisation

DHBs were well aware of both the imperative to prioritise and the existence of many significant restrictions on their capacity to do so. The most commonly cited restriction was the 'weight of history', which often included dealing with deficits. Informants from all case study DHBs stated that their budgets were almost exclusively pre-determined by existing contracts with health providers and national policy settings. In terms of being able to allocate resources based on local needs and values, DHBs commented that some contracts had long lead times to completion (e.g. with contracts having three year terms), and they were generally not prepared to terminate contracts prematurely unless there were performance issues (IR: 50). A number of case study DHB respondents involved in funding and planning claimed that only about 1% of the budget could possibly be reallocated.

A second type of constraint identified was the parameters set by central government. This view was often forcefully expressed. According to one DHB informant, *'...there's nothing to prioritise, everything is given ... all the fields are mandatory'* (B: 35). CEOs also commonly claimed that DHBs were not free to disinvest from existing services as such decisions would ultimately end up on the Minister's desk.

> *'Despite the work on a prioritisation framework, at the end of the day most of that will be escalated to the Minister, because basically the public sector is not allowed to stop doing anything that it does.'* (CEOS: 13)

A specific example illustrating this concern occurred in one case study DHB early in the study period. The Board actively attempted to terminate its funding of infertility services which had been ranked low as a result of priority ranking of all contracts. The Minister of Health vetoed the main proposal that came out of this process (which recommended some disinvestment in infertility services). This veto encouraged the DHB management to recommend to the Board that any major disinvestment decisions should be undertaken at a national rather than a district level (EIR: 40).

National policy settings could also affect the capacity to reallocate funds within services.

> *'Continued ring-fencing of mental health funds is reported to be hindering innovation in mental health services, the ability to be more responsive to local needs and to move towards more outcome oriented contracts.'* (A: 32)

Community resistance was another constraint on priority-setting. One DHB didn't act on their prioritised rankings because the services with low scores *'we wouldn't withdraw as we wouldn't get it past the community'* (D: 52).

In some case-study DHBs, the restrictions to prioritisation were seen as overwhelming. In Case Study B, informants were scarcely able to identify any examples of changes in prioritisation from one year to another (B: 35). In another, the constraints were not regarded as worth worrying too much about, as current funding patterns were regarded as *'tend[ing] to fit with the HNA and prioritisation'* (D: 52). Yet for some other DHBs, such constraints were not an excuse to give up on attempts to prioritise. One CEO commented:

> *'We don't do all the provider arm and then see what we have left for elsewhere. Even though we had a significant deficit last year, there were new programmes supported first because they aligned with our DSP.'* (CEOS: 13).

4.3 New Investment and Disinvestment

For DHBs that were net beneficiaries of the Population Based Funding Formula (PBFF) funding adjustment, this shift reflected some increased room to manoeuvre. Where they occurred, reports of new resource allocation were overwhelmingly in primary and preventive services.

Two case study boards reported more capacity for investment in new services as a result of increases in funding through PBFF.

> *'You could imagine if we already had our funding and it's not going to increase and we have priorities that are different from what our current service structures are, or service base and contracts are, we would have to down size or try to capture some of the existing revenue to apply it to new areas of prioritisation. We're in a fortunate case of receiving new money and can apply it to those areas of priority* (C: 18).

In another, PBFF enabled the DHB *'to set aside a still very small strategic fund to fund initiatives at the margin in some of the strategic areas'* (E: 29). Some case study boards clearly identified that they had channelled more money into cardiovascular health, cancer and diabetes.

One DHB had set aside $1m per year for new projects in the form of a Strategic Investment Fund, but there was some frustration expressed that this money had not yet been allocated (A: 31). According to one informant, *'just about everything'* in the DHB's identified needs exceeded one million dollars (A: 31).

Only one of the case study boards explicitly identified examples of disinvestment (Case Study C). These were the closure of an intellectual disability institution and the closure of long-term aged care facilities as these services were transferred over to private and NGO providers. Neither of these could be regarded as the product of prioritisation processes. The first of these decisions had been taken by the Ministry in the 1990s (before the DHB era).

4.4 General Comments

Taken together with evidence from other sources, the picture of prioritisation is as follows. There is recognition in DHBs of the importance of explicit priority-setting and a general acceptance of the key elements of the Ministry/Joint DHB framework.

Whatever the origins of the frameworks used, however, there are issues of technical feasibility. Case study DHB research indicated that a number of DHBs had prioritisation frameworks on the books, but they were generally not operational. None of the case study DHBs could point to sustained prioritisation exercises that drove the reallocation of funds.

However, DHBs *have* made changes to their overall pattern of resource allocation that *are* in line with government strategies. This is primarily a product of the release of new money and incentives from the centre than from DHB-driven frameworks, but DHBs have also been very keen to use whatever flexibility they have to achieve a closer alignment with national priorities such as primary care.

Prioritisation needs to be seen within the broader context of strategic planning, new government funding and government strategies. Shifts in funding since the introduction of DHBs are more a reflection of these broader parameters than fine-grained prioritisation processes. Strategic planning (big picture) and prioritisation (more fine-grained) are only loosely coupled.

Prioritisation frameworks may be most useful to DHBs when they are deciding how to spend new money, but even here, the research indicates that prioritisation tools have had little impact. Because so many projects and service areas are competing for limited funds, it is probably inevitable that such decisions are made subject to the political dynamics within DHB boards and organisations.

It is clear from the research that prioritisation processes are not used to reallocate historical funding patterns. In this respect there is nothing particularly novel about the experience of the last five years in New Zealand. Rather than indicating a significant failure of individual DHBs and the DHB model, this finding needs to be seen in the light of previous New Zealand experience and international research into priority-setting by health authorities with a local, geographical basis (NHC 2004b; Mitton & Donaldson 2002).

5 Implementing Government Strategies

Since the election of the Labour-led government in late 1999, the key vehicle for advancing health policy has been the device of 'strategies'. The headline strategy has been the New Zealand Health Strategy (NZHS) which establishes the government's policy commitment to a population-based approach to health. The New Zealand Disability Strategy provides a framework for addressing needs of people with disabilities. Other key health strategies include the Primary Health Care Strategy (PHCS), the Māori Health Strategy and the Health of Older Peoples Strategy.

5.1 Support for Strategies but Concerns about Implementation

By the end of 2004, most of the case study boards saw their planning documents as local manifestations of national priorities. In Case Study E, many respondents remarked upon the commonality between Ministry and DHB priorities in primary care. (E: 27), and in Case Study B *'even the most dissenting members of the Board haven't moved against the Strategies'*. (B: 34).Given the substantial agreement within the sector regarding the broad objectives of the health strategies, successful implementation was identified as the key issue.

One senior (Ministry) official noted that rather than rationally planning through designing a new system and then implementing it, the approach that has been taken with the PHCS is to run an:

> *'...emergent strategy which grows bottom up: it's actually about sowing the seeds of innovation, ideas. Getting the people back on board that are willing to go and try to do it'.*

This approach to policy reform clearly locates responsibility for implementation of government strategies at the local level. While DHBs and the local health sectors appreciated the opportunity to devise their own approaches and solutions, they also often expressed frustration with what they saw at times as a lack of practical guidance and sheer scope and scale of innovation they were expected to foster. According to one stakeholder respondent:

> *'...the Ministry doesn't believe that it's their role to make operational policy but nor is there any other national body with responsibility to lead implementation, and this was seen to be a "vacuum" (NS: 15)*

In the 2002 round of case study interviews DHB respondents often commented that there were too many strategies, and that DHBs could not give adequate attention to them all at the same time (case studies). In response to this criticism, key officials thought the Minister had been clear about where DHBs should start. However, from a DHB perspective, even the 'start here' list seemed too broad. From the 2004 round of case study interviews it became clear that DHBs regarded some strategies, generally the PHCS and He Korowai Ōranga, as the most central.

Government strategies were certainly important in terms of board time and energy, but due to the difficulty of reallocating resources it was sometimes difficult for DHBs themselves to see how this translated into practice. Strategies were seen as more effective when linked to funding streams.

Without exception, the strategies are reflective of the directions that opinion leaders and key stakeholders in various parts of the health sector see as necessary. However, the capacity of existing organisations to meet these aspirations in the short-term is constrained by factors such as organisational boundaries, funding and occupational work practices. The danger of setting expectations too high was a constant theme in interviews throughout the sector.

One national stakeholder organisation expressed it as follows:

> *'Sometimes nationally governments announce a national strategy and it pumps up people's expectations that things are going to happen in a reasonable timeframe, which often isn't delivered on. And whereas at the local level the DHB are, they're one part of a chain and we're another part of that chain and they are as constrained as we are to a certain extent by the resources and the timeframes and the constraints that government's put on them so we've almost sort of able to sit around the table and say, well, realistically this is what we can do in this community in this period of time.'* (NS: 14).

According to a respondent from one of the case study DHBs, the NZHS is:

> *'...very idealistic and if the funding was there it would be brilliant. But it really worries me that we're expected to put that strategy into place and how we're going to do it, how we're going to afford to do it I don't know. The thing that worries me most is that I think it could well engender false expectations in the community'* (D: 38)

DHBs sometimes struggled with accepting responsibility for new strategies and requirements from central government when there was no additional funding attached to the strategies. One case study informant noted that 'there are still good ideas coming out from the centre' which were expected to be incorporated into the DHB business plan without extra funding attached. The Restraint Policy was cited as an example (A: 32). In one DHB, the example was given of the value placed on ageing in place in the Health of Older Peoples Strategy but noted that home help is down to one hour per week for those ill with such problems as cancer (D: 38).

The strategies have also been used as a way to engage stakeholders and communities – the goal of improved population health has received wide support in local health sectors. A strength of the Strategies was seen to be that they:

> *'....have forced the sector to start thinking from the consumer or recipient end of the services. I'm not sure the sector does that very well. I still think there's a 'provider-in' rather than a 'consumer-out' focus.'* (NS: 15)

In some cases, conflicts between local health sector players often open up when attempts are made to give flesh to the bones of the strategies. For example, Case Study E developed a very clear strategy regarding PHO development in the district, stipulating a range of 2-4 PHOs in order to avoid competition between PHOs. However, this strategy met considerable and successful resistance from various local providers who wanted the DHB to pursue a more flexible approach (E: 27).

5.2 Feedback on Specific Strategies

5.2.1 Primary Health Care Strategy

In the second round of interviews with key informants, Ministers and officials expressed their pleasure with the progress of the Primary Health Care Strategy.

Among provider-based stakeholders, there was general agreement with the emphasis of the PHCS. There was also the impression more resources had gone into the implementation with more engagement between the Ministry and the DHBs. Some concerns were expressed, that there is debate how much innovation the PHCS will allow, and how responsive the PHOs will be to the local communities (NS: 51)
In 2004, stakeholders reported considerable variation throughout the country with the rate of implementation of the PHCS. Some DHBs were working on how to involve not-for-profit providers, whereas other DHBs were still working out what needed to be done (NS: 13).

Among professional organisations, the Primary Health Care Strategy was seen to be *"probably the most central strategy within the whole platform of strategies and it does require a really quite substantial rebuilding of approaches'* (NS: 30). However, the professional organisations predominantly worked at the national level and engaged with the Ministry rather than with individual DHBs, and as such were not well-placed to comment on implementation at the district level.

Among board members, the perception of hospital dominance decreased over time. Between 2002 and 2004, the proportion of surveyed board members who disagreed or strongly disagreed with the statement that 'Board discussion is dominated by hospital issues' rose from 32% to 41%, while the proportion agreeing or strongly agreeing with the statement fell from 39% to 28% (BMS:51)[1].

5.2.2 Disability Strategy

The guiding philosophy of this strategy is the need to eliminate barriers that prevent the participation of the disabled in society. As such, it affects all sectors of activity including health. With regards to the health sector, and DHBs in particular, the key emphases of the NZDS has been the removal of barriers of access to services and barriers to employment in health sector organisations. The strategy challenges the providers of services to support disabled people in leading the lives they want, rather than requiring them to fit in with the array of services provided. DHB Disability Services Advisory Committees (DSACs) have a central role in the implementation of the Disability Strategy.

While disability sector stakeholder organisations were supportive of the NZDS, they did express concern about what they saw as the absence of concrete steps and goals.

> *'... the whole document is effectively a vision rather than a strategy, it doesn't have timelines or anything like that ... [when] the document came out [it] was not really reflecting the concrete steps the group would have wanted but it did have a general reflect of the vision .... I wish it had a bit more teeth'* (DS: 25).

By the time of the second round of interviews, the Ministry of Health were reviewing DHB DAPs in the light of the NZDS. It was reported by both Ministers and officials that some DHBs identify their role in relation to disability issues only in relation to funding for disability service provision rather than improving the responsiveness of all services to better meet the needs of people with disabilities.

[1] There was statistically significant variation between DHBs on this question.

Some DHBs did take steps to make the strategy more concrete. Stakeholder organisations reported examples including a DHB disability advisor writing 'something concrete' for the DHB to translate the Strategy into action and another DHB had taken the approach of addressing staff attitudes towards equity and raising awareness of what it means to be disabled. It was hoped that other DHBs would follow this lead (DS: 26).

Comments from case study DHB informants reflected the intersectoral nature of the strategy. One informant commented the disability strategy is:

> *'...harder to get your head around because some of the outcomes and goals are wider intersectoral ones and therefore harder to measure* (D: 39).

5.2.3 Health of Older People Strategy (HOPS)

The devolution of funds for the older disabled population was the catalyst for the DHBs to implement the HOPS. They were now driving change much faster in response to the communities' resources and feedback than if those funds had been left with central government. Some DHBs were known to have established older persons' health advisory committees. Examples were cited of DHBs who were paying attention to transport and housing issues, demonstrating a focus on health rather than hospital services (DS: 27).

HOPS was one strategy in which claims of an implementation gap were made more forcefully. There were concerns that the different DHBs may have quite different priorities resulting in increasing inconsistencies. With regard to the Health of Older People Strategy, one NGO informant saw a 'yawning gap' between what is determined nationally and how that may be translated locally. (NS: 14)

This is one strategy that prompted stakeholder respondents to wonder about the relationships between strategies. Concerns were expressed over the lack of coordination, both between the various health and disability strategies and between the agencies leading the implementation. The PHCS work has not been integrated

with that of the HOPS, yet the changes in primary health care have major implications for older people, for example the coordination of primary care services. It was noted that, unlike some other strategies, there was no implementation 'toolkit' produced to accompany the HOPS (DS: 28).

Generally, the strategies are reflective of the directions that opinion leaders and key stakeholders in various parts of the health sector see as necessary. However, the capacity of existing organisations to meet these aspirations in the short-term is constrained by factors such as organisational boundaries, funding and occupational work practices. The danger of setting expectations too high was a constant theme in interviews throughout the sector.

6 Assessment

Have DHBs adopted a strategic focus on population health goals?

DHBs have clearly moved towards a strategic focus on population health goals. There is also significant support within the health sector for the broad vision of the New Zealand Health Strategy. 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.

Our research shows that there is substantial buy-in in the DHB community to the key elements of the process and substance of strategic decision-making as envisaged in official government policy. By and large, the strategic directions being pursued by DHBs have been consistent with the New Zealand Health Strategy. The fact that DHBs have been created to focus specifically on the health of overall populations has certainly assisted this cultural change.

Strategic decision-making is necessarily broad-brush and helps considerably to set the tone for the DHB organisation and the broader health sector in the district. With the complexity of health systems, even at the district level, it is often difficult for participants to gain a firm grasp of the overall picture.

How does strategic level commitment to population health goals translate into policy change?

Strategic decision-making has proven useful for DHBs to focus on the drivers of population health. However, DHB organisations do not have many levers of change readily at their disposal, and those working at the local level are only all too aware of the gap between expectations and capacity.

Implementation of national and local strategies is also highly dependent on local political dynamics. When all 'the stars are in alignment', DHBs are able to make considerable progress in bedding down national and local strategies. DHBs have shown a willingness to engage in local innovation when they are able to access earmarked central government funds. When partners and stakeholders are in broad agreement about where to go and how to get there, the current model has shown that there is the potential for great achievement.

While overall strategic decision-making remains an important focus of DHB activity, our research shows that changes to practice (actual decision-making) are most prevalent at the level of particular services. While these changes may be broadly in line with overall strategic direction, they do not necessarily emerge explicitly from strategic frameworks. Where innovation in DHB practice is occurring, it tends to occur mainly in 'bite-sized' chunks. The impetus for these changes comes from DHB staff, local community organisations and providers often working closely together.

Has the tension between community preferences and central government requirements been problematic?

The tension at the heart of DHB's organisational environment has, on balance, been less problematic than might have been expected. At the overall level of organisational objectives, there has been a good fit between national policy directions and local priorities, and DHBs. The national strategic framework has provided DHBs with a clear substantive focus that may not have otherwise been achieved. Furthermore, the research did not find any examples of disagreement between DHBs and central government over strategic direction.

The picture is more complicated at the more specific level of concrete decision-making. Here, by and large, the autonomy of DHBs remains relatively limited, although it has been increasing slowly. In practice, there is not that much scope for DHBs to make decisions that are inconsistent with national policy settings, or significant departures from historical patterns of resource allocation.

Because local community input is predominantly focused on service design, the area of overlap between national and local influences on decision-making has, in practice, been quite small. While there is some friction between the local and national levels, it has been between DHB managers and central government, rather than between local community preferences and Ministerial requirements.

Do DHBs have sufficient autonomy to be effective strategic decision-makers?

Overall, DHBs have demonstrated 'the will' to engage in strategic decision-making processes to enhance population health. The commitment is clearest in DHBs' formal strategic planning. However, the real challenge lies with translating strategic planning into actual changes. While there is a will, there is often difficulty in finding a way. DHBs are charged with the responsibility for implementing government policy, and are given the discretion to search for local solutions to both local and national health problems.

The capacity of DHBs to be effective decision-makers is heavily circumscribed by the context in which they operate. They operate in an environment in which decreases in funding for existing health services are politically problematic for both the DHBs and central government. For DHBs to advance their strategic decision-making, they are very reliant on co-operation from providers within the organisation, contracted providers and other key stakeholders such as consumer advocacy groups. This means that if 'the stars are not in alignment' – if there is resistance, then DHBs can struggle to make headway.

The flexible deployment of available resources is vital to strategic decision-making. But the capacity of DHBs to engage in strategic decision-making is curtailed by the fact that they have little control over their sources of revenue, and, in practice not a great deal of flexibility over how resources are deployed. Our research shows that for many DHBs the degree of flexibility and the perception of flexibility are slowly increasing, particularly if they have population characteristics that are rewarded by the PBFF.

Nevertheless, the priorities and requirements of central government and the weight of institutional history will continue to be the most influential factors on DHB decision-making and practice, with flexibility and innovation exercised at the margins. Opportunities for change are largely dependent on the availability of new funding from central government.

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