



Health Reforms 2001 Research Project

Report No. 5

**DEVOLUTION IN NEW ZEALAND'S
PUBLICLY FINANCED HEALTH CARE SYSTEM**

Jacqueline Cumming

On Behalf of the Health Reforms 2001 Research Team

August 2007



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Table of Contents

Introduction to the Health Reforms 2001 Research	v
Overview and Key Findings.....	vii
Executive Summary	xiii
1 Introduction.....	1
2 Background.....	3
2.1 Frameworks for Analysis.....	3
2.2 International Research on Decentralisation	7
2.3 Analysing Decentralisation in New Zealand	18
3 Health Reforms 2001 Research	23
3.1 Framework for Analysis	23
3.2 Research Methodology and Methods	24
3.3 Data Analysis.....	27
4 Research Findings.....	28
4.1 Findings – The NZPHDA Model and Devolution – Intentions	28
4.1.1 Cabinet Papers	28
4.1.2 The NZPHD Bill and NZPHD Act.....	34
4.1.3 The Views of Key Informants	37
4.2 Findings – Early Experiences with the Model.....	40
4.2.1 A Local Focus.....	40
4.2.2 Devolution of Funding and Decision-Making.....	45
4.2.3 Capacity and Capability.....	59
4.2.4 Collaboration Between DHBs	61
4.2.5 Adaptation of the Role of the Ministry of Health.....	67
4.3 Findings – Later Expectations and Experiences	71
4.3.1 Expectations.....	71
4.3.2 A Local Focus.....	74
4.3.3 Devolution of Funding and Decision-Making.....	80
4.3.4 The Role of Central Government in Funding and Planning Decisions	98
4.3.5 Number and Size of DHBs	115
4.3.6 Capability and Capacity.....	119
4.3.7 Collaboration between DHBs	122
4.3.8 Adaptation of the Role of the Ministry of Health.....	139
4.3.9 Other Issues	152
4.4 Responsibility for Decision-Making.....	153
5 How Can the Model Be Improved?	157
6 Discussion.....	164
7 Conclusions	178
Appendix 1	179
Summary of Findings on Decentralisation as Reported in Peckham et al (2005).....	179
References	191

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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Overview and Key Findings

This paper is one of a series reporting on findings from the Health Reforms 2001 Research Project. The Project was undertaken to chart the progress of, and evaluate, the health reforms enacted by the New Zealand Public Health and Disability Act 2000 (NZHPDA), as they were implemented. This paper reports on findings relating to devolution.

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

As the research has progressed, the researchers have observed that the degree of devolution envisaged by the NZPHDA model and the degree of devolution that is viewed as desirable in New Zealand are contentious issues. This report draws on the research findings from all sources of data obtained during the research, as well as on international and New Zealand literature on devolution.

This paper presents findings on the issue of devolution within the NZPHDA model, drawing on research which took an evaluative approach to the development of the NZPHDA model over the 2002-2005 period. As well as a literature review, the research involved two rounds of data collection – the first (2002/03) focusing on expectations and early experiences with the model; the second focusing on later experiences (2004/05). The research involved key informant interviews with government ministers and senior officials in the Ministry of Health; interviews with DHB Chairs and CEOs; and surveys of DHB Board members.

The research also involved in-depth case studies in five districts, which included interviews within DHBs and with local providers, observations of DHB Board meetings and analysis of documentation. Qualitative data for this research were analysed thematically; quantitative data were analysed using descriptive statistics; and the researchers have triangulated findings across time and across the various data sources.

Key Findings from the Literature Review

The literature review focused on recent (post-1990) published and unpublished articles, books and reports on decentralisation, which includes devolution. Overall, the international literature shows that decentralisation, and research into the effects of decentralisation, is a complex topic. It suggests that the context in which decentralisation occurs, and the way in which decentralisation is organised, will be key factors in how a decentralised system performs. The main issues which arise where countries are moving towards decentralisation or devolution relates to the actual balance of decentralised and central decision-making that develops in practice, and to how central government guidance and monitoring on decision-making impacts at a local level. The literature suggests that often a degree of both increased decentralisation and increased centralisation can occur at the same time.

The literature also finds there is limited evidence of the impact of decentralisation on key policy goals, and much of the evidence is seen to be equivocal. The evidence does suggest that there may be a positive relationship between decentralisation and health outcomes, but there remain concerns over the measures used and the findings may not necessarily apply in New Zealand. The evidence also offers some support that decentralisation (and local decision-making autonomy) may promote trust and that decentralised agencies are seen to be closer to their local communities and may better promote equity of access within regions, as decentralised agencies are more responsive to local needs. There is also some evidence that decentralisation may reduce costs through better resource use and where there is competition.

On the other hand, there are concerns over majority groups dominating decision-making and over the potential for a decentralised system to lead to increasing inequities across regions. There also remain concerns over whether decentralisation results in missing opportunities to benefit from economies of scale, but the evidence on the relationship between the size of an organisation and its performance is seen to be equivocal, with size suggested as only one factor involved in determining performance.

Thus, the literature suggests that key trade-offs may occur between achieving a degree of equity (of access) across districts and economies of scale on the one hand (suggesting larger organisations and less decentralisation), and responsiveness, local accountability, technical efficiency and equity within districts on the other (suggesting greater degrees of decentralisation).

Key Findings from the Health Reforms 2001 Research

Early findings from the research found strong support overall for the NZPHDA model, with key strengths including the local focus of the model, the ability to involve the community in decision-making and the ability to be responsive locally. Key weaknesses included perceived dual accountabilities, the large number of DHBs, issues relating to capability and capacity, and in particular, a perceived lack of actual devolution during implementation. Many key informants pointed to higher than desirable levels of central control in the model. Early specific concerns related to delays in devolving DSS funding; continued central government responsibility for public health funding; unduly prescriptive requirements on DHBs leaving little room for DHBs to demonstrate local leadership; and micro-management by the Ministry of Health.

The early phases of the research also showed some support for having national strategies, and informants noted that potential conflicts between these strategies and local needs assessments had not in fact been a significant issue. Informants suggested there were too many strategies and there were concerns over lack of funding associated with strategies.

Later findings similarly showed support overall for the NZPHDA model, with an increased recognition of the importance of taking a population, community-based approach to health. Key weaknesses were similar to those identified in the first round of the research (noted above), and there was increasing concern over the perceived lack of devolution of decision-making to DHBs and on-going involvement of the Ministry of Health in DHB decision-making. Those working in DHBs particularly were concerned about the potential problems from DSS funding now being split between DHBs and the Ministry of Health; public health funding remaining with the Ministry of Health; too many strategies, lack of implementation and funding and a focus on a one-size-fits-all approach; and too many prescriptive directives and control from the Ministry of Health, including a time-consuming performance management regime. There were however some alternative views, with some DSS providers preferring to continue to contract for DSS for those aged 65 and under with the Ministry of Health, and a mix of views on the desirability of devolving public health funding.

Informants across the research felt there are too many DHBs but there was no support for forced amalgamations, while DHBs have found a number of ways of working collaboratively to manage issues and services.

Relationships between DHBs and the Ministry of Health were seen to be positive and improving, but with a desire for the Ministry to have a greater focus on policy, and concerns over ‘silos’ within the Ministry of Health, and on-going issues relating to perceived inappropriate involvement of the Ministry of Health in key activities at a local level.

DHB Board members in a survey on devolution overall sought increased decision-making ability at a local level, particularly in relation to priority-setting, but also in relation to appointing members to the DHB Board, selecting the DHB Board Chair, deciding which advisory committee the Board adopts, selecting providers to contract with and negotiating user charges in primary health care.

Key Conclusions

The report concludes that many of those working in the sector at a local level feel that New Zealand has not sufficiently devolved decision-making to a local level, and that further devolution should occur in future. Many see potential gains in relation to finding local solutions to local problems, while also ensuring that DHBs can make their own financial decisions to ensure they can deliver an appropriate mix of services to best meet local needs while also remaining within budget.

This is, however, not a universal view. Those working at a central government level feel less comfortable with a more devolved approach, as the New Zealand population is argued to be likely to continue to hold central government to account for key decisions in health, and as a result of concerns over inequities/inconsistencies in access to services around New Zealand where key decisions are taken locally.

With the reforms now five years old, this is an opportune time for the government to refine the NZPHDA model. Policy makers need to begin by considering what the key goals are for the health sector; in particular, deciding on which goal is paramount – encouraging local responsiveness or promoting a greater degree of equity and national consistency. They then need to consider how the NZPHDA model as currently configured promotes achievement of that goal. A focus on local issues might suggest there will be further gains from greater devolution and less centralised decision-making. A focus on equity of access across regions and a desire for national consistency may require current or even greater levels of centralised decision-making, and some gains in efficiency might then be achieved by reviewing the current structures and roles of DHBs.

Executive Summary

This paper is one of a series reporting on findings from the Health Reforms 2001 Research Project. The Project was undertaken to chart the progress of, and evaluate, the health reforms enacted by the New Zealand Public Health and Disability Act 2000 (NZHPDA), as they were implemented. This paper reports on findings relating to devolution.

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

As the research has progressed, the researchers have observed that the degree of devolution envisaged by the NZPHDA model and the degree of devolution that is viewed as desirable in New Zealand are contentious issues. This report draws on the research findings from all sources of data obtained during the research, as well as on international and New Zealand literature on devolution.

This paper presents findings on the issue of devolution within the NZPHDA model, drawing on research which took an evaluative approach to the development of the NZPHDA model over the 2002-2005 period. As well as a literature review, the research involved two rounds of data collection – the first (2002/03) focusing on expectations and early experiences with the NZPHDA model; the second focusing on later experiences (2004/05). The research involved key informant interviews with government ministers and senior officials in the Ministry of Health; interviews with DHB Chairs and CEOs; and surveys of DHB Board members.

The research also involved in-depth case studies in five districts, which included interviews within DHBs and with local providers and stakeholders, observations of DHB Board meetings, and analysis of documentation. Qualitative data for this research were analysed thematically; quantitative data were analysed using descriptive statistics; and the researchers have triangulated findings across time and across the various data sources.

Findings – Literature Review

An extensive literature review has been undertaken as part of this research, focusing on recent (post-1990) published and unpublished articles, books and reports on decentralisation, including devolution. The literature review provides a framework for analysis for this research. It also shows that decentralisation, and research into the effects of decentralisation, is a complex topic. It suggests that the context in which decentralisation or devolution occurs, and the way in which it is organised, will be key factors in how a decentralised or devolved system performs. The main issues which arise where countries are moving towards decentralisation or devolution relates to the actual balance of decentralised and central decision-making that develops in practice, and to how central government guidance and monitoring on decision-making impacts at a local level. The literature suggests that often a degree of both increased decentralisation and increased centralisation can occur at the same time.

The literature also finds there is limited evidence of the impact of decentralisation or devolution on key policy goals, and much of the evidence is seen to be equivocal. The evidence does suggest that there may be a positive relationship between decentralisation and health outcomes, but there are concerns over the measures used and the findings may not necessarily apply in New Zealand. The evidence also offers some support that decentralisation (and autonomy) may promote trust, and that as decentralised agencies are more responsive to local needs, they are seen to be closer to their local communities, and may also promote equity of access within regions better than more centralised approaches. There is also some evidence that decentralisation may reduce costs through better resource use and where there is competition.

On the other hand, the literature points to on-going concerns over majority groups dominating decision-making and over the potential for a decentralised system to lead to increasing inequities across regions. There also remain concerns over whether devolution of decision-making to a larger number of local agencies results in missing opportunities to benefit from economies of scale which might arise from having fewer agencies. However, the evidence on the relationship between the size of an organisation and its performance is seen to be equivocal, with size suggested as only one factor involved in determining performance. Thus, the literature suggests that key trade-offs may occur between achieving a degree of equity (of access) across districts and economies of scale on the one hand (suggesting larger organisations and less decentralisation), and responsiveness, local accountability, technical efficiency and equity within districts on the other (suggesting greater degrees of decentralisation).

Findings – Early Experiences of the Model (Round One of the Research, 2002/03)

Early government documents about the NZPHDA model appeared to stress the importance of funding and decision-making being devolved to DHBs over time (for example, in developing a structure that *‘devolves responsibility for local planning and funding to DHBs, who understand and can best represent the needs of their local community’* (King no date-a)). DHBs were also expected to be accountable to the Minister of Health, and to work within national frameworks, including the NZ Health and Disability Strategies (*‘DHBs will be responsible for deciding on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, NZ Disability Strategy and nationwide minimum service coverage and minimum quality standards...’* (King no date-e)). Potential tensions and problems in these arrangements were recognised, but the overall tenor of cabinet documentation was towards devolution to DHBs, enabling DHBs to decide on the best mix of services at a local level and for local communities to have a greater say in decision-making in relation to the mix of services provided.

In introducing the legislation to Parliament, the then Minister of Health similarly stressed the role of the community within the NZPHDA model (with the reforms *‘restoring community involvement in and ownership of health at a local level’*, and *‘strengthening local community input’* (King 2000b)). She also noted the role of the

New Zealand Health and Disability Strategies in guiding the sector, while DHBs were to ‘*gradually assume responsibility*’ for funding or providing services locally, ‘*leading the population approach to health care*’. National strategies would guide the sector, and a number of accountability mechanisms were put in place to ensure accountability of DHBs to central government.

Key informants interviewed for this research – Ministers, senior officials in the Ministry of Health and The Treasury, senior officials from the HFA – noted the importance of a population health focus in the new model, as well as of community involvement in decision-making. Local engagement was seen as important to improving health, and the NZPHDA model was contrasted with the previous model, with DHBs seen as being closer to their communities. However, key informants, particularly those in government, also stressed that DHBs are clearly accountable to the Minister of Health, while devolution of decision-making to DHBs was to occur within national frameworks. Some informants saw this as a potential key source of tension in the model, suggesting this could be reflected at the local level by frustration at the lack of freedom for real local leadership, while others noted that devolution was in fact planned as an evolutionary process. Overall, there was some recognition that perhaps 21 DHBs was too many, although some concerns were expressed over DHBs having large communities to work with, with different needs, if there were fewer than 21 DHBs. Co-operation between DHBs and possible voluntary amalgamations were seen as the most appropriate way to manage issues relating to the number of DHBs established under the NZPHDA model.

The first round of data collection at a local level found strong support for key aspects of the NZPHDA model. Support came from across the range of those taking part in this research, including those surveyed in a public survey, those working in DHBs, providers, those working at a local community level, and national stakeholders. Key strengths included the local focus of the model, including involving the community in decision-making, and the ability to be responsive locally. However, a number of key weaknesses in the model were also identified, including in relation to perceived dual accountabilities in the model; the number of DHBs; capacity and capability; and, in particular, to a perceived lack of actual devolution during implementation. Many informants also pointed early on to higher than desirable levels of central control in

the model, leading to limited local autonomy. Informants pointed to a seeming reluctance to devolve funding and decision-making on the part of the Ministry of Health, with the Ministry having too great an involvement in operational matters. Although these concerns were raised particularly by those working in DHBs, other informants also suggested that a too high a degree of central control was an issue with the model.

Specific points raised in interviews on devolution are set out below.

In relation to devolution of funding and decision-making for disability support services – Concerns were expressed by some DHB informants in the case study research over delays in devolving funding for services for those with disabilities aged 65 and over; and by some informants over the decision to keep funding for services for those with disabilities aged less than 65 with the Ministry of Health. At times this was put down to the Ministry of Health not trusting DHBs to spend money as required. However, disability stakeholder groups and providers in one case study DHB were more likely to view disability support services as different from health services, with little support from non-DHB providers for further devolution. Informants were particularly concerned about disability concerns being swamped by mainstream health concerns and budgetary pressures. National stakeholders had mixed views on this issue, with some informants seeing benefits in working on these issues more flexibly at a local level with DHBs. National stakeholder informants pointed to concerns over potential loss of national consistency, potential problems with co-ordination and duplication, increased costs from working with 21 DHBs, and capacity issues for DHBs and noted the need for safeguards for devolved funds and adequate resources for DHBs.

In relation to devolution of funding and decision-making for public health services – The research also showed there were some concerns in some case study DHBs that the decision for public health funding to be held centrally went against the vision of promoting population health, including health promotion and disease prevention. For example, one informant stated: *'the ultimate paradox is that, in the legislation, Boards are charged with protecting, promoting and improving the population health - great. And yet population health funding is still retained at the Ministry and directly*

from the health units...'. There were, however, different views on this issue, with some informants supporting retaining funding and decision-making at a central level, in order to promote national consistency and to retain a critical mass of public health expertise in a single organisational setting.

In relation to the role of government strategies – Informants across the research pointed to the powerful role that national strategies were playing in relation to local (DHB) strategic planning and decision-making. Some explicitly noted that these national documents are useful; for example one informant commented: 'Basically for us He Korowai Ōranga and the Primary Care, whānau ora is basically what we have based our strategic plan on'. Informants also suggested there would be concerns if these conflicted with local issues and needs, although in practice, it appeared that this had not been a significant issue, with DHBs' local HNAs providing a framework for providing information on local needs to balance with national strategies. Informants in DHBs did suggest there are too many strategies, and there were at times concerns over the lack of funding associated with strategies, with one informant's views on the New Zealand Health Strategy reflective of the interviewees' views generally: '[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'.

In relation to the role of central government in planning and funding decisions – This was the area where the greatest concerns were expressed by informants surveyed or interviewed in this research, particularly by those working in DHBs. A combination of national strategies, service coverage specifications, deficit reduction requirements, and service level requirements were seen to be 'unduly prescriptive' and to leave DHBs with little room to demonstrate local leadership. In one DHB, it was determined that prioritisation at a local level was not feasible in the current environment. Some informants pointed to examples of direct government involvement in decision-making as undermining their ability to make local decisions.

In relation to capacity and capability – The first round of research found that informants did have some concerns over the NZPHDA model and how it would support capacity and capability to undertake key tasks, from planning and decision-making through to service delivery. Some concerns were expressed over DHB Board capabilities, particularly in relation to financial skills and depth of knowledge of the health sector. In DHB organisations, early concerns focused on the capacity and capability to manage contracts, in relation to Māori, Pacific, and public health expertise, and in terms of monitoring hospital performance, while other informants pointed to concerns over primary health care expertise in DHBs and in relation to the ability of DHBs to undertake HNAs. The research also found numerous ways in which DHBs were collaborating, in part to overcome issues relating to capacity and capability (eg, through Shared Services Agencies for analytical and contracting issues), but also to reduce the potential for fragmentation of services and to improve co-ordination (through Regional Mental Health Networks or RHMNs and other service-level collaborations), to reduce administrative costs (eg, through inter-DHB collaborations) and to ensure DHBs have a voice in working at a national level (eg, through District Health Boards New Zealand or DHBNZ).

In relation to the adaptation of the role of the Ministry of Health – Overall, relationships between the Ministry of Health and DHBs were seen to be good or improving, but concerns were expressed by DHB Board members, CEOs and staff over micro-management of issues by the Ministry of Health. One informant commented that: the DHB was going to *'get the accountability delivering services, but we aren't going to get the responsibility for making the changes because so much as been prescribed'*. There was a perception that the Ministry had a large resource that had changed little, and that it had shifted from funding back to policy, nor upgraded its skills to reflect this change (for example, by beefing up monitoring). It was suggested by some that there was too much activity at a central level, with Ministry staff working in silos. The overriding concern was about a lack of clear lines of demarcation between the DHBs and the Ministry of Health.

Findings – Later Experiences of the Model (Round Two of the Research, 2004/05)

In relation to devolution, there were stronger views expressed around concerns over a perceived lack of adequate devolution to DHBs and over DHB autonomy during the second round of data collection compared with the first round of data collection.

In key informant interviews with Ministers and senior officials in the Ministry of Health, informants noted the importance of community involvement in health as crucial to improving the health of communities and to reducing inequalities. One key informant reflected on how the model strongly supported a public health approach:

‘...from a public health perspective...it’s not just about democracy...community engagement is actually about changing the way community works in, on public health matters. So if you look at the Ottawa charter it’s about healthy public policy and community engagement. If you’re going to get people to stop smoking you need families and communities and support’ (KII 8 R2).

In relation to devolution, Ministers and officials felt they did not always know what was meant when it was suggested that DHBs did not have sufficient autonomy, and they felt that DHBs do have the autonomy to make decisions, for example around health strategies and goals. Officials pointed to central government funding and political responsibility for health, and a desire for consistency, as key issues in this debate (*‘New Zealanders believe in fairness ...we all want access on the same terms...’* (KII 9, R2)), with some informants suggesting that the model may develop with increasing autonomy over time, so that in five years time, the way in which the model worked could look different.

Informants throughout the research continued to strongly support the model, and the population health approach and local focus envisaged by it. DHB Chairs commented on *‘a sense of community ownership again’*, *‘a local focus for all health services’*, with *‘increased public confidence’* in the system overall. Several Chairs also suggested that the reforms did, however, involve major change, with a significant investment of time required throughout DHBs to ensure change occurred properly. No Chairs expected benefits to flow quickly: *‘success will be over the long haul’*; *‘it will take 15 years’*. Other informants agreed on the benefits of working locally, with one informant voicing the views of many when they noted that local people:

'are always going to have greater knowledge of what the local needs are and the local people are the ones that are going to have to carry out the projects, [they] need to have an input...a degree of ownership...for them to be able to actually make it work. It's never going to work when someone in Wellington says this is your priority when the local people don't believe it is a priority, well they're not going to make that work are they?'

Key issues again related to some concerns over perceived dual accountabilities in the model, capacity and capability, including on DHB Boards in relation to strategic thinking, and over the impact of financial deficits on implementation of aspects of the model. Some informants from professional organisations felt not much had yet changed on the ground in DHBs, and raised some concerns over limited consultation and over how community engagement was actually to occur.

In addition, it was suggested that there remained higher than desired levels of central control. The DHB Board member survey showed fewer Board members in 2004 agreeing that the DHB has sufficient autonomy, and more DHB Board members agreeing there are times when the Ministry and government interfere inappropriately in the work of the DHB, than in 2002. In free text, DHB Board members similarly noted comments reflecting concerns over the degree of central control by the Ministry of Health and government, and over interference from the centre in DHB decision-making. DHB CEOs also felt there is too much central control and they looked to having a more *'hands-off'* approach, with less work generated from the centre. Informants in the case study research similarly reflected concerns over the Ministry of Health's involvement in decision-making, while NGO informants reflected on the tension between having national consistency and allowing an individual community response to local issues. Professional group key informants similarly questioned whether DHBs had real autonomy or whether devolution of decision-making had been oversold. In contrast, DHB Chairs accepted the role of government as funder and policy maker, and recognised this may limit DHB decision-making from time to time, but did not seem to see this as a major problem, and although some Chairs did identify some restrictions on their decision-making, none were considered serious barriers.

Specific issues raised in the second round of data collection are set out below:

In relation to devolution of funding of DSS – Funding for DSS for those aged 65 and over had been devolved to DHBs at the time of the second round of interviews. Ministers and officials noted that DSS for those aged less than 65 years of support day-to-day living needs rather than health, hence the need to consider whether the health sector is the most appropriate location for the funding for these services. Informants noted that there are issues relating to the interface between funding and services as people with disabilities turn 65 years of age, and where services are closely aligned to DHB services, and complex contracting arrangements where organisations have contracts for both population groups.

However, concerns were also expressed over the complexities and costs of having 21 DHBs contracting for services if DSS for those aged less than 65 were devolved, and over potential lack of national consistency, including in relation to prices paid for care. One key informant felt that DSS should be devolved where services closely align to DHB services; while another noted that they had previously been apprehensive about funding going to DHBs, but now felt that DHBs were doing a great job, and that DHBs were driving change in relation to the Health of Older People Strategy faster than if funding stayed with the Ministry of Health.

At a local level, DHB Chairs and CEOs were mostly positive about devolution of funding of services for those aged 65 and over, although they had concerns over the process of devolution. In the case study research, the advantages of devolution of funding of DSS were seen to be greater flexibility and fluidity in service provision to meet the specific needs of individuals, and reducing boundary issues between services. Some informants suggested there could be problems across the funding boundaries, including in relation to DHBs as funders for health services carrying the risk of funding decisions taken at a central level in relation to younger people with disabilities, and for patients as they turned 65 years of age. This was a concern for Māori, who tend to show age-related conditions prematurely.

Informants had mixed views about the desirability of further devolution of DSS funding (for services for those aged under 65 years of age). Full devolution of DSS funds was generally supported by DHB respondents but not by third sector providers. Some informants felt that DSS should be regarded differently to mainstream health services, and although the potential benefits of devolution in improving integration of services were acknowledged, there was little support from third sector providers for further services to be devolved to DHBs. Informants were particularly worried that devolution might lead to decreased levels of funding if decisions were made at the DHB level and feared that disability concerns would be swamped by mainstream health concerns and budgetary pressures. Others preferred to leave the management of the younger disabled within social services to avoid disruption:

'In fact I would argue against moving it because it just creates a huge amount of disruption, slows advances in service delivery by at least two years while everybody sorts out the process and I mean we're never going to get it right ... what we need to work on is the coordination and the models of service, not which side of some sort of arbitrary dividing line that gets administered from'.

Still others were concerned about losing national consistency and about placing disability issues in a medical paradigm.

In relation to devolution of funding for public health services – At a local level in DHBs, there was general support for devolution of public health funding, particularly in the context of a focus on population health, and in order to align spending with local priorities in health. There were some differing views on this, however, with some suggesting that it is appropriate for some contracts to be held at a national level, given concerns to avoid fragmentation and loss of economies of scale. Where devolution itself was not supported, those interviewed in DHBs did desire for a greater say over how the available funding was spent. A separate piece of research on this topic noted similar differences of opinion (Slater 2006).

Some informants were supportive of a national approach in order to retain a whole-of-system view and leadership, reap economies of scale from having a few nationally negotiated contracts rather than 21 local contracts, and retain expertise centrally. Others saw benefits in local decision-making, by enabling DHBs to adapt services

locally, enabling DHBs to explore economies of scope across personal and public health services, enhancing DHBs' abilities to improve population health and promote integration, and enhancing the ability to tailor services to better meet local needs, given significant differences in the populations DHBs work with.

In relation to the role of government strategies – As with the first round of data collection, many informants approved of having national strategies, although they noted some concerns relating to a one-size fits all approach, lack of implementation processes in some cases, and a lack of resources to follow through. Government direction was seen by DHB Board members to be a key influence on DHB priority-setting, but the relationship with the centre was also seen as a barrier to achieving gains at a local level, arising from detailed control by the Ministry of Health and the costs of complying with requirements. DHB Chairs also acknowledged the importance of the NZ Health Strategy, and particularly the Minister's 'start here' list in determining local priorities, with a few acknowledging these can limit local priorities. Some informants at case study DHBs noted that their own plans and priorities reflected those of central government, and in some case it was noted that this prevented there being concerns over conflicts between local and central priorities. Informants noted concerns over lack of funding, there being too many strategies to implement at once, and concerns where national strategies can limit local flexibility.

In relation to the role of central government in funding and planning decisions – As in the first round of data collection, informants noted concerns over the role of central government in decision-making. These comments were generally reflected throughout the research, although, as noted above, some DHB Chairs reported no real constraints on decision-making. However, some Chairs did raise concerns over the lack of funding for new policies and programmes that DHBs were expected to introduce, limits on local flexibility from the Minister's 'start here' list, the impact of the need to break even on attempts to work even with the 'start here' list, and balance of decision-making, with a need to challenge the Ministry of Health from time-to-time. Chairs also had a view that DHBs are over-governed and over-monitored, and this was associated with a desire for more local autonomy. Chairs recognised that DHBs are spending public money and need to be accountable for this but *'we still want more flexibility and would like them to leave us to do more things'*.

CEOs similarly suggested that a key barrier to priority-setting at a local level was that some decisions needed to be made at Ministerial level. CEOs also commented on the need for co-ordination at the Ministry of Health level, including across strategies, on there being too much central control from the Ministry of Health, and on the demands made in relation to monitoring. A number of CEOs commented on the overall size of the Ministry of Health and its ability to generate more work than DHBs can handle. Specific comments were also made in relation to the PHCS, with some feeling that DHBs were left *'out of the loop'*.

In the case studies, informants expressed similar concerns, commenting on: the *'slowness'* of devolution, the Ministry being involved a lot with DHB activities, a desire for more autonomy and less monitoring, and the need for greater clarity over the respective roles of the Ministry of Health and DHBs. Specific concerns were raised over: mental health ring-fencing hindering local flexibility; national contracts, policies and programmes placing requirements on DHBs in relation to funding levels and expenditure; PHO implementation excluding DHBs, being rolled out at a pace beyond which could be managed at a local level, and involving policies which impact on DHB strategies; tertiary hospital risks not being fully appreciate; service volumes being dictated by the Ministry of Health; problems reconfiguring services; lack of engagement with DHBs over major policy issues; and concerns over extensive performance monitoring and management processes. National stakeholder and professional organisation informants also raised concerns in relation to central decision-making. Informants noted tensions between policies aimed at promoting national consistency and issues relating to affordability and the possible gains that might come from flexibility of service delivery at a local level, while some informants also queried whether DHBs had real autonomy at a local level, as reflected in the views of the informant who commented:

'In the early stage, 2001, it felt to me almost as if the model was being over-sold – you know, communities will have the authority, the power and will be able to solve our problems and I thought, "That's not going to happen". Not that quickly anyway, and it hasn't happened. I think it could go a bit further and more quickly than it has. There is still a reluctance I think to trust DHBs to do things and maybe to make some mistakes ... Every now and again you read comments from a DHB Board or a member saying they're frustrated they aren't able to do much at all, and that would

be my observation. The Boards have got less room to do things differently than they probably should have. So I think local input is important. The structure is developed to deliver it but the processes I don't think are really there yet'.

In relation to the number of DHBs – In the second round of data collection, it was frequently suggested that there are too many DHBs. This issue was raised by informants throughout the research. Concerns were raised over the viability of small DHBs, and in relation to capacity and capability for planning and funding roles as well as in relation to service delivery (eg, in relation to mental health, public health, surgical services and cancer treatment). Some noted the high level of transaction costs from providers having to work with so many DHBs, but while some suggested that efficiency gains would result from amalgamations, others felt that little was to be gained from amalgamations. Some informants raised concerns over the implications of having 21 DHBs for national consistency. Forced amalgamations were not supported, however, and it was felt that DHBs should be working together more, while also retaining the local focus of DHBs:

'...but you can't get away from the communities of interest and parochialism that exists in New Zealand. So I actually wouldn't change too much...' (CEO 3)

'There's other ways of achieving good results by amalgamating some functions...there's amalgamation of a lot of functions...there's a lot more collaboration than there used to be'. (CEO 11)

'Right now, the [A] and [B] boards are busy talking about looking at regional service delivery. Now, whether that means that there will be two DHBs or one eventually - who knows? But in terms of service provision we will see a seamless entity'.(CEO 9)

'You don't have to amalgamate boards. You can achieve the same things (savings, sharing expertise, etc) in a different way and still maintain the real philosophy behind DHBs, which was local responsiveness and local ownership.' (CEO 5)

In relation to capacity and capability – In the second round of data collection, DHB Board members identified a range of training needs, around funding and financial matters, orientation to the DHB and in relation to the health care system. DHB Chairs suggested that capability had increased over time, with considerable effort on the part of Chairs to achieve this. CEOs generally felt positive about their Boards, feeling Boards had settled into their functions well. They raised concerns over the

commitment of resources to HNA and strategic planning processes for smaller DHBs, with national stakeholders also considering these skills to be relatively scarce, and now split between 21 DHBs. In the case study research, it was also noted that small DHBs are required to do the same tasks as larger DHBs, with much less capacity. Shortfalls in planning expertise were also noted in the research by several informants.

In relation to collaboration between DHBs – The research has found that DHBs are working to overcome some of problems generated by lack of capacity and capability by collaborating through a range of mechanisms and in relation to a range of planning and service delivery tasks. Many informants in DHBs spoke positively of the role of DHBNZ in facilitating relationships with the Minister and in facilitating regional collaboration, as well as working on industrial relations and technical issues. Some felt this role could be developed more, while many informants noted the need for DHBs to retain decision-making rights. Informants in DHBs also commented positively on the role of the SSAs. Individual DHB-DHB relationships were also seen by those working in DHBs to be generally developing well, particularly in relation to non-clinical and administrative services, as well as in relation to clinical services, with a need to collaborate to maintain viability of some services (eg, mental health, surgical and medical specialties and laboratory services) in some districts. Some tensions between DHBs were evident, however, and some concerns were expressed over the impact of collaboration on DHB autonomy, more paperwork and more meetings, but generally those interviewed saw collaboration as positive. The research found mixed views about the usefulness of the Regional Mental Health Networks (RMHNS), with some informants suggesting there is a lack of clarity about their role, and others noting that the networks complicate issues relating to accountability, which formally lies with individual DHBs.

In relation to the adaptation of the role of the Ministry of Health – In the second round of data collection, DHB Chairs noted positive and improving relationships with the Ministry of Health. The quality of the relationship with the Ministry was seen to be improving over time, with this attributed to high levels of mutual respect (*'we're no trouble to them, and they're no trouble to us'*), the hard work invested in maintaining the relationship, and the calibre of some senior executives in the Ministry (Gordon Davies, then Deputy Director-General, DHB Funding and Performance,

received a number of ‘bouquets’). A number of specific examples were given to illustrate the approach of the Ministry: *‘they managed a difficult transition well’*; *‘they managed the intensive monitoring situation well’*; *‘they are very open and accessible now’*. Within in this context, Chairs also noted areas where relationships could improve, in particular around DHBs being seen to be over-governed and over-monitored, and a desire for more flexibility:

‘I think they [the Ministry] have managed the transition very well. And I think it's an evolving system and it's remarkable what's been achieved in the last four or five years. We have total respect for them. We get frustrated with them and they get frustrated with us, but overall we're very complementary....There is a tendency not to completely let go. If you're going to make an organisation [the DHB] accountable, then don't put in excessive checks and balances, because you just end us with excessive bureaucracy’. (C 11)

‘I think we really have respect for each other's roles and positions. We make sure our board members know what the Ministry has to deal with at their end, because it's not all 'beer and skittles' for them. They have to deal with Treasury, with the Ministers, with a whole heap of other agencies and I think that it's important that our board...understands the barriers they have there...but we still want more flexibility and we would like them to leave us to do more things’. (C 6)

CEOs were generally more positive about the Ministry of Health in the second round, as a result of the development of working relationships. Positive comments were made, with the Ministry described as helpful, positive and flexible, with good relationships at times, as well as an improving situation with respect to stability in Ministry of Health staff, more regular communication, and working together to improve relationships. CEOs expressed concerns over the need for a greater focus on policy, and silos within the Ministry, as well as over the involvement of the Ministry in key activities, including the implementation of the PHCS.

In the case study research, reports on relationships with the Ministry of Health were mixed. Some informants commented positively on the relationship with the Ministry and the value they placed on these relationships: *‘The Ministry in general were extremely supportive’*; and: *‘Sound working relationship’*. Others were less complimentary. However, the key concern remained over the respective roles of the Ministry and DHBs. Some comments were made suggesting the need for a greater role for the centre in relation to tertiary services, information technology, information

management, technology assessment and simpler contracting, but overall the Ministry of Health is seen to be involved too much in working with DHBs (*'almost week by week direction'*), in developing too many strategies, in requiring significant amounts of reporting and monitoring. Similar comments were made by national stakeholder informants working in NGOs and in professional organisations. Specific comments included:

'There's a tension, every day it's a tension'.

'The idea that Boards are autonomous, that Boards have all the power required for full governance is not correct. I think the Board functions best when it sees itself as a fully-owned subsidiary'.

'[The Ministry of Health is] far too operational, [had] its fingers in far too many pies, [was] slow to hand over responsibility...and resource'.

A survey of DHB Board members in 2004 also included questions about the current roles of the key decision-makers in the health care sector and about where DHB Board members felt decision-making ought to lie. The survey shows overwhelming support from DHB Board members for more local level (ie DHB) decision-making as opposed to central decision-making.

How can the model be improved? – Informants we interviewed for this research suggested a number of improvements to the NZPHDA model. In this context, many noted the importance of allowing the reforms time to bed down and there was no support for further, major structural reform.

Key ideas for improvements which were consistently identified by informants across the research related to increased local decision-making, with less central direction. The expected benefits from increased local decision-making included working flexibly and innovatively at a local level with local providers and local communities; considering service improvements across the health and independence sector; integrating services at a local level across DHB and private provision; and focusing on services which best meet local needs. Informants also suggested there be fewer Strategies, in order to focus on and consolidate progress in a few key areas at a time and to enable DHBs to give attention to local priorities.

Many informants particularly wished to see a streamlining in performance management processes, in order to reduce DHB workloads and free up management time and attention which could then be spent on developing or improving services.

Although many informants commented on their being perhaps too many DHBs, forced amalgamations in particular were not supported in the research; rather informants suggested increased collaboration across DHBs. Informants also suggested that there is a need for increased training, capability and capacity in relation to planning, purchasing/contracting monitoring and leadership skills. Primary health care and disability support services expertise was also seen as important for DHBs.

Finally, informants made a number of suggestions in relation to the role of the Ministry of Health – suggesting clarification of the role of the Ministry of Health, a need for improved senior analytical skills at the Ministry, and recognition that the level of demands from the Ministry generally, and specifically in relation to reporting, are seen to outstrip the capacity of the sector. There was also a desire for increased trust throughout the system, and increased co-operation and responsiveness from, and co-ordination within, the Ministry of Health.

Discussion

Devolution of Funding

The original intent of these reforms was for funding for most services to be devolved to DHBs, as DHBs showed themselves capable of managing these responsibilities. The reforms have indeed resulted in the devolution of much health and DSS funding to DHBs. However, funding for DSS for those people with disabilities who are aged less than 65 years of age, and for public health services, remains with the Ministry of Health.

This research has found a mix of views on the desirability of devolving responsibility for these services to DHBs – in general, DHB informants preferred to have the funds devolved while other groups had mixed views as to the desirability of further devolution. Although there are potential problems which may arise with responsibility for the DSS funding to be split between the Ministry of Health and DHBs, there

remain concerns that the health sector is not philosophically attuned to working with the needs of younger people with disabilities, as well as concerns over the impact on national consistency if services were fully devolved to DHBs and over the impact of devolution on those non-government organisations which would need to work with 21 DHBs in organising services. In terms of public health funding, although some national contracts may be too small to divide between the 21 DHBs, the research suggests that retaining this funding centrally does not support the message that DHBs have a key role to play in relation to population health, health promotion and disease prevention. Over time, however, as DHBs and PHOs put their own resources into this area, it is likely that public health funding at a local level will increasingly become more important relative to national programmes.

Devolution of Decision-Making

Once funding is devolved to DHBs, we might expect that a high degree devolution of decision-making to DHBs would automatically follow. Our research, on the one hand, suggests that it was anticipated that there would eventually be a high degree of DHB autonomy within the NZPHDA model. However, it was also expected that DHBs would work within national strategies, and within nationwide service coverage and quality standards in making purchasing decisions and in providing services. Throughout the research we have found a lack of clarity as to how these two conflicting approaches would, in practice, balance out.

The research has shown that many informants believe that DHBs have insufficient autonomy and that there is a desire for greater devolution of decision-making to DHBs, along with less direct involvement of the Ministry of Health in planning, decision-making, and monitoring. Not all the participants in this research supported this view, however. Some participants working at a central level have a view that DHBs have a lot they can decide upon, but that in order to promote national consistency and ensure accountability for central government funding, a degree of centralised decision-making is no bad thing.

Our findings on this issue very much mirror findings in the international literature in relation to how the process of decentralisation works in practice. The international literature points to the complexities involved in implementing decentralisation, and

the opposing forces which can operate to reduce decentralisation in practice. These arise in part due to sensitivities over control and direction of the system and possibly as a result of central government agencies traditionally being held to account for decision-making in the health sector by citizens at regional or central levels (Allen 2006).

In reflecting on devolution within the NZPHDA model, those interviewed for this research have identified the influence of the same issues found in the international literature on devolution. That is, they point to a tension between, on the one hand, achieving equity of access goals across the country, obtaining economies of scale from having larger rather than smaller organisations, and ensuring capacity and capability to undertake key tasks; and on the other hand, promoting local responsiveness and technical efficiency.

In this vein, in moving the NZPHDA model forward, New Zealand policy makers firstly need to decide on the degree of devolution that is appropriate for New Zealand. This needs to be done by considering which of a number of key goals New Zealand is trying to achieve, first and foremost, for its health and disability sector. A focus on local responsiveness supports a stronger degree of local decision-making, while a focus on equity across regions, and a strong desire for central government accountability, may require a high degree of central decision-making.

As part of this, we should consider what the international literature tells us about whether devolved or centralised systems do generally achieve their respective goals. The international literature reviews referred to here find that the evidence in relation to the impact of devolution on key policy goals is limited, often weak, and equivocal in many cases. There is, however, some support for devolved models focusing on local needs and for promoting responsiveness and allocative efficiency goals. Our research has found that many in the sector agree with the potential in this area – in particular, a number of participants in this research felt that local decision-making is helped along by closer working relationships at a local level, and that services can be better tailored at a local level to meet local needs as a result of devolved decision-making.

Although there does appear to be potential in achieving these key goals through increased devolution, the international literature also points to possible concerns over devolved models of decision-making. Of particular relevance in New Zealand are, possible concerns at a local level in terms of how majority groups may come to dominate decision-making, making it difficult for those from smaller groups to have their voice heard. In New Zealand, similar issues may arise in relation to the perceived place of ‘cinderella’ services, such as DSS, public health, mental health and primary care, and in relation to Māori and Pacific health issues. The literature does not readily identify ways of better managing these issues, but the use of ring-fenced budgets and strong performance management processes should be investigated further in the NZPHDA context.

The international evidence also suggests there are on-going concerns that devolved decision-making may lead to increasing inequities across regions, but there is a lack of evidence as to whether inequities increase across regions or whether improvements in equity occur within regions as a result of devolution, and whether centralisation results in improvements in equity. A fair allocation of resources to districts with likely higher needs will be a first necessary step in promoting equity (Koivusalo, Wyss et al. 2007). Some regulatory measures (for example, enhanced performance management processes) (Koivusalo, Wyss et al. 2007) will also be required in New Zealand to ensure a focus on equity of access, but as noted in this research, careful attention needs to be paid to the balance of central regulatory and local decision-making responsibilities and to the clarification of key roles within the sector.

In the NZPHDA model, the appropriate number of local decision-making authorities, in this case, the number of DHBs, is also a key issue. This too has been raised as an important issue in the international literature. Many informants in New Zealand generally feel that 21 DHBs is too many, but for most, concerns over the number of DHBs were not sufficient to suggest that DHBs should be forcefully amalgamated. The international literature suggests there is no one optimal size for organisations in health. This suggests that the current approach of encouraging collaboration between DHBs is a good way forward. The key will be to ensure that appropriate pressure is placed on DHBs to make efficiency gains, so that they have appropriate incentives to seek out, for themselves, the most appropriate ways of working together.

In the context of the NZPHDA model and where it goes from here, having identified which key goals New Zealand is trying to achieve with its health sector, and which of the goals may be most achievable given the international evidence and the findings from this research, policy makers need to make decisions about whether the current structures adequately support working towards those goals.

If the over-riding goal is to promote local responsiveness in New Zealand, this research suggests that the balance of decision-making needs to further support local decision-making. The research suggests that a rethink of the role of central mechanisms is required to achieve this, and for further thinking around the role of national Strategies, the type of consistency that is being sought in New Zealand, and the role of the Ministry of Health. The research has also identified a number of areas where we need increased capability and capacity – in particular around planning, purchasing/contracting, monitoring and leadership skills, and for improved knowledge and understanding of primary health and disability support services within DHBs.

In spite of a desire by many in the sector to further promote local decision-making, the researchers recognise that strong accountability to central government is difficult to avoid in the New Zealand health sector and that, rather than trying to promote local responsiveness, the Government may have a desire for increased consistency in service coverage, access and ways of delivering services than is likely to occur under the current NZPHDA model. If a decision were made that the current balance of decision-making seems right or even that there is a need to tilt the balance of decision-making further towards central decision-making, then the NZPHDA model may require redesigning. In particular, it is likely that the local structural arrangements established under the NZPHDA – for example, local governing Boards and statutory committees, local needs assessments, strategic and annual planning, local purchasing and contracting, and local community engagement – are too cumbersome to support centralised decision-making. If many decisions are to remain centralised, this raises the questions as to why there are 21 DHBs and a strong local structure to support them.

Conclusions

The 2001 health reforms are considered by many to have been in part about devolution of funding and decision-making to local agencies (DHBs), in order to increase the role of local communities in decision-making. This research has shown that many of those working in the sector at a local level feel that New Zealand has not sufficiently devolved decision-making to a local level, and that further devolution should occur in future. Many see potential gains in relation to finding local solutions to local problems, while also ensuring that DHBs can make their own financial decisions to ensure they can deliver an appropriate mix of services to best meet local needs while also remaining within budget. This is, however, not a universal view. Those working at a central government level feel less comfortable with a more devolved approach, as the New Zealand population is argued to be likely to continue to hold central government to account for key decisions in health, and as a result of concerns over inequities/inconsistencies in access to services around New Zealand where key decisions are taken locally.

With the reforms now five years old, this is an opportune time for the government to refine the NZPHDA model. Policy makers need to begin by considering what the key goals are for the health sector; in particular, deciding on which goal is paramount – encouraging local responsiveness or promoting a greater degree of equity and national consistency. They then need to consider how the NZPHDA model as currently configured promotes achievement of the paramount goal. A focus on local issues might suggest there will be further gains from greater devolution and less centralised decision-making. A focus on equity of access across regions and a desire for national consistency may require current or even greater levels of centralised decision-making, and some gains in efficiency might then be achieved by reviewing the current structures and roles of DHBs.

1 Introduction

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 (NZHPDA), the government established 21 District Health Boards (DHBs) as local organisations responsible for population health and for the purchasing and provision of health and disability support services at a local level. This paper is one of a series reporting on findings from research undertaken to chart the progress of, and to evaluate, these reforms as they were implemented.

This paper reports on findings relating to devolution. Devolution has been defined as 'the creation or strengthening of sub-national levels of government which are substantially independent of national level for some defined set of functions' (Rondinelli 1983; Mills 1990). In New Zealand, planning and resource allocation and management functions have been restructured a number of times over the past 20 years, and the latest reforms – establishing DHBs under the NZPHDA model – can be considered a form of devolution.

In planning research on the NZPHDA model, the research team identified a number of potential gains and losses that might arise from devolving responsibilities to DHBs, as planned under the NZPHDA, which would form the basis for research on the topic of devolution. As the research has progressed, the researchers have observed that the degree of devolution envisaged by the NZPHDA model and the degree of devolution that is viewed as desirable in New Zealand are contentious issues.

This report draws on the research findings from all sources of data obtained during the research, as well as on international and New Zealand literature on devolution. Readers are referred to accompanying reports for greater detail on the research methods and findings from particular sources of data, as well as to papers reporting on the findings on other issues: governance; strategic decision-making; health needs assessment and prioritisation; financing, purchasing and contracting; Māori health; and Pacific health.

The report is divided into a number of sections:

- Section 2 – Background
 - Frameworks for Analysis
 - International Research on Decentralisation
 - Analysing Decentralisation in New Zealand
- Section 3 – Health Reforms 2001 Research
 - Framework for Analysis
 - Research Methodology and Methods
 - Data Analysis
- Section 4 – Research Findings
 - The NZPHDA Model and Devolution – Intentions
 - Early Experiences With the Model
 - Later Expectations and Experiences
- Section 5 – How Can the Model be Improved?
- Section 6 – Discussion
- Section 7 – Conclusions

2 Background

The details of this research were originally set out in a proposal by the research team to the Health Research Council of New Zealand. That proposal noted that the move to DHBs aims to strengthen the public health system, achieving the best outcomes and reducing disparities, ‘by removing the competitive model and addressing the distancing of communities from decision making’. Compared with the ‘quasi’-market model introduced in New Zealand in 1993 and which the NZPHDA model replaced, the move to DHBs implied a number of changes with respect to governance, purchasing and accountability. In particular, the research team noted that the move to the NZPHDA model could be described as a form of devolution.

Devolution has been defined as ‘the creation or strengthening of sub-national levels of government which are substantially independent of national level for some defined set of functions’ (Rondinelli 1983; Mills 1990). Devolution itself is considered a form of decentralisation. In this section, we note the key frameworks for thinking about decentralisation and devolution and provide an updated summary of international and New Zealand research on devolution and decentralisation.

2.1 Frameworks for Analysis

Mills (1990) provides the most common framework used for thinking about devolution in health care. Her approach is based on the work of Rondinelli (1981; 1983), which focuses on issues relating to decentralisation. Four main types of decentralisation have been identified in these literatures:

- Deconcentration – where some administrative authority is handed over to locally-based offices of central government ministries;
- Devolution – the creation or strengthening of sub-national levels of government which are substantially independent of national level for some defined set of functions;

- Delegation – the transfer of managerial responsibility to organisations outside a central government structure, and only indirectly controlled by central government;
- Privatisation – the transfer of government functions to private for-profit or not-for-profit organisations (Rondinelli 1983; Mills 1990).

In health, Mills has also identified a range of functions that can be decentralised, including, for example, legislating, revenue-raising, policy-making, regulating, planning and resource allocation, management, inter-sectoral collaboration, inter-agency co-ordination, and training. This list excludes service delivery functions, which are usually undertaken in a decentralised way, given the need for services to be delivered to individuals or groups of individuals at a local level.

Rondinelli's and Mills's framework provides a useful means by which approaches to decentralisation can be categorised. There are then a number of theoretical approaches which have developed as frameworks for analysis relating to decentralisation. These have been summarised recently by a number of authors.

Bossert (1998) notes four theoretical frameworks relating to decentralisation. First, is a *public administration approach*, which focuses on the distribution of authority and responsibility for health services, in terms of a national political and administrative structure (eg, as in Rondinelli's and Mills's work). Second, is a *local fiscal choice approach* (or '*fiscal federalism*' approach), which analyses choices made by local governments using their own resources and resources transferred to them by other levels of government (Musgrave 1959). This economic approach assumes that local governments compete with each other for voters who are assumed to be mobile and that local governments make choices to satisfy the preferences of what is known as the 'median' voter. Third, is a *social capital approach*, which aims to explain why decentralised governments in some localities perform better than governments in other localities, as reflected in the work of Putnam (Putnam 1993). Fourth, is a *principal-agent approach*, also developed by economists, to examine how a 'principal' with specific objectives can encourage 'agents' acting on their behalf to achieve the key goals of the principal, given a context in which agents usually have much better information about what they are doing than principals. Bossert notes that

the strength of this approach is that it encourages a focus on the relationship between the centre and the periphery. It can also be adapted to consider cases where there are multiple principals (eg, where there are locally elected boards who are accountable to central agencies), but the approach requires a way of defining shifts in the ranges of control of principals and agents.

Bossert goes on to combine aspects of the principal-agent model with the administrative approach, describing a 'decision-space' by which to describe the functions that may or may not be decentralised. Key aspects of the relationships between the centre and the periphery then to be analysed include performance measures; incentives and sanctions; information and monitoring; motivations and goals of agents; and capabilities of the agent.

Hurley *et al* (Hurley, Birch et al. 1995) develop a more detailed model using concepts drawn from organisational theory and the economics of information to suggest that decentralised structures have the *potential* to better promote technical and allocative efficiency than more central structures. This is because local decision-makers will have better ability to incorporate all relevant information into decision-making and to learn from experience and innovation than central decision-making. They also suggest that the allocative efficiency gains from local decision-making are 'directly proportional' with the degree to which local communities have different values, preferences, needs and local circumstances, while technical efficiency gains are related to variations in local conditions relating to the production of services (Hurley, Birch et al. 1995, p.10).

Jiminez and Smith (Jiminez and Smith 2005) focus their work in particular on the theory of fiscal federalism, which favours sub-national provision of local public goods and services on the basis that local preferences and costs are likely to vary across jurisdictions (Musgrave 1959; Oates 1972). Here, sub-national levels of government are argued to have access to better information about local circumstances than central authorities, and are able to tailor services and spending patterns to meet local needs. In this model, efficiency gains are expected as a result of sub-national decision-making, in part as a result of these informational issues, but also as a result of a degree of competition between jurisdictions and from greater experimentation and

innovation. Gains from decentralisation are, however, dependent on effective channels through which individuals at a local level can signal their preferences, and incentives on local policy makers to respond to these preferences. On the other hand, centralisation may well be more efficient as a result of information distortions, or weak oversight that might occur at a local level, or as a result of low levels of fiscal discipline at a local level, especially where financial transfers occur from central to local government, and where central government is in fact generally held accountable for problems. Positive economies of scale might also favour centralisation, while equity considerations may also lead to a need for redistribution of resources from richer to poorer areas.

In the United Kingdom, Peckham *et al* have further developed these frameworks in the context of thinking about decentralisation in the English National Health Service (NHS). They develop an ‘Arrows Framework’, which suggests a direction of movement along a horizontal axis – the *where* of decentralisation – and levels of activity in relation to *what* is being decentralised, and further developing a framework for assessing the evidence for decentralisation, including in relation to inputs, processes and outcomes (Peckham, Exworthy et al. 2005). This framework is particularly useful in considering a wide range of issues relating to decentralisation, as it includes global and multi-national roles as well as the roles of professionals and patients, and can encompass a range of inputs, processes and outcomes in terms of what is in fact being decentralised. They then assess the evidence for decentralisation, focusing on key criteria/goals of outcomes, processes, staff morale, humanity, equity, responsiveness and allocative efficiency, technical efficiency, adherence and accountability. A summary of their findings is presented below.

Saltman and Bankauskaite (Saltman and Bankauskaite 2006) also focus specifically on a framework for thinking about decentralisation within health care. They distinguish between political decentralisation (moving authority to lower levels of government); administrative decentralisation (giving greater authority to ‘line’ personnel); and fiscal decentralisation (where fund-raising and spending decisions occur at a local level). Political decentralisation is seen to have advantages in better reflecting local considerations, in promoting democratic participation, and in promoting greater efficiency. Its key disadvantage is seen to be a potential lack of

uniformity or inequity, as well as potential inefficiencies and duplications from having multiple agencies involved in health care. The main purpose of this approach is to allow mid- and lower-level public sector administrators to become active managers and to run their units on a more entrepreneurial basis. Fiscal decentralisation has the theoretical advantages of better enabling regional differences to be taken into account, generating competition amongst local governments in order to promote innovation and promoting the preferences of local communities where people can move between districts.

2.2 International Research on Decentralisation

A number of reviews of the literature have been published on decentralisation and health. Mills (1990) focused on issues relating to the processes of decentralisation, particularly in developing countries. More recent reviews have been undertaken by Bossert (Bossert 1998); Jiminez and Smith (Jiminez and Smith 2005); and Peckham, Exworthy, Powell and Greener (Peckham, Exworthy et al. 2005), the latter providing a recent and very thorough review of the literature. A number of studies have also reviewed the experiences of particular countries with respect to decentralisation, and some of these are included here, including an overview of recent European experience undertaken by Saltman and Bankauskaite (Saltman and Bankauskaite 2006).

Mills *et al* (1990) reviewed the experiences of a number of countries, in implementing decentralisation policies. The focus of their work was on decentralisation for developing countries; however, the issues raised are very relevant in the New Zealand context. They first noted how decentralisation takes place in a particular historical context in each country and that decentralisation is implemented by different governments in quite different ways. In the case studies they reviewed, Mills *et al* noted that reforms in health care often follow on from reforms more generally across the state sector and that degrees of decentralisation and centralisation often occur at the same time. The case studies also suggested that it takes at least five-to-ten years '*from the formulation of decentralization policies to their implementation*' (Mills 1990, p.141) and up to 10 years or more before a decentralised system works well.

Mills *et al* noted a number of features common to decentralisation experiences across their case study countries. These included:

- A need to improve the central Ministry of Health's capacity in health planning so it can develop comprehensive national policies, plans and guidelines;
- A need for strengthened health information systems;
- A need for management support to staff in regions and districts;
- That decentralisation often points to poor co-ordination within Ministries across vertically-organised programmes and there are often complaints that Ministries are slow to respond to this;
- Involvement of non-governmental and private organisations in decentralisation is often difficult, with a need for legislation, statutory regulations, financial subsidies and controls;
- The importance of boundaries being similar across governmental functions in order to promote intersectoral collaboration and co-ordination (Mills 1990).

Mills *et al* noted that the most sensitive issues in decentralisation are often around revenue raising and controlling expenditure, including prioritisation – that is, which organisations have the right to decide how the health budget is divided between different priority services and programmes, and how much flexibility there should be in budgeting. Often there are also problems in co-ordinating different finances (eg, public and private funds). Funding districts in equitable ways is also a key issue. Staffing issues were also identified as important – with decentralisation, some parts of the country may find it more difficult to find staff while senior management and health planning skills are often in short supply. Finally, Mills *et al* also noted that implementation policies are key to achieving decentralisation, and that small scale reforms adopted over a long period of time, accompanied with clear financial responsibilities, orientation and training, strengthening of lower level authorities and clarified responsibilities will be more likely to succeed.

Bossert (Bossert 1998) briefly summarises literature pertaining to the four approaches to decentralisation he identifies. In relation to the local fiscal choice approach, Bossert notes that studies of federal systems find that central governments are more effective in making equitable allocation decisions (in particular, providing assistance to the poor) and that local governments use funds more effectively to achieve efficiency and

quality objectives. A key issue is the role of inter-governmental grants, which are seen often to drive out local funds rather than to stimulate local funding. Bossert has also noted the short-comings of this approach, including the assumption that local authorities will respond to the desires of the 'median' voter when many other factors impact on local choices. In relation to the social capital approach, he reports on the research of Putnam (Putnam 1993), who has found that the density of civic institutions (eg, voluntary organisations such as soccer clubs, choral societies) create social capital or social experience which encourage people to work together and to trust each other. Such trust enables better performance in local institutions. Putnam has suggested that localities with a long history or strongly established civic organisations will have better performing decentralised governments. However, Bossert notes that a concern with this approach is the lack of policy-relevant conclusions that can be taken from existing research, especially given the focus on the long history of development of civic organisations, and the conclusion that decentralisation will work only in some communities with a long history of strong social capital. Bossert notes that this approach suggests research and policy should focus on the local context in which decision-making takes place.

Jiminez and Smith (2005) report a number of studies in developing countries where a decentralised public sector (ie not just health) has led to improved health outcomes. This includes research by Mahal *et al* (Mahal, Srivastava et al. 2000) using data from rural villages in India, which finds a positive relationship between decentralisation and child poverty; Asfaw *et al* (2004) which find similar results for rural India, and also showing that the effectiveness of fiscal decentralisation increases with the level of political decentralisation. They also cite research by Robalino *et al* (Robalino, Picazo et al. 2001), which is a cross-country study using measures of the proportion of sub-national spending over central government spending against infant mortality rates, for the 1970-1995 period. They control for a range of factors and find that decentralisation is associated with lower infant mortality rates, although the marginal benefit of decentralisation is found to be greater at low income levels. Yee (Yee 2001) is also reported as finding a beneficial impact through reduced mortality and increasing local health expenditures in association with fiscal and political decentralisation, in 29 Chinese provinces for the period 1980-1993. Ebel and Yilmaz (Ebel and Yilmaz 2001) find positive effects from intervention by sub-national

governments for immunisation rates for DPT and measles in children under 12 months of age in six developing countries (Argentina, Brazil, Colombia, Philippines, South Africa and Venezuela) for the 1970-1999 period. Habibi *et al* (2001) find a negative and significant association between the percent of revenue raised locally and the proportion of controlled revenue over the total with infant mortality rates for Argentinian provinces between 1970 and 1994, as well as a significant reduction in inequalities. Khaleghian (Khaleghian 2003) also examines the relationship between decentralisation and immunisation for DPT3 and measles of children at one year of age in 140 low and middle income countries for the period 1980-1997. This study finds that decentralisation improves coverage rates in low income countries, while in middle-income countries, decentralisation is associated with lower coverage rates.

Jiminez and Smith go on to analyse the impact of health sector decentralisation on health outcomes. They use data on the ration of sub national health spending to total health spending as a measure of decentralisation, focusing on Canada for the period 1979-1995, and on the association of decentralisation with infant mortality. The results suggest that decentralisation did have a positive influence on infant mortality rates.

Peckham *et al* (Peckham, Exworthy *et al.* 2005) undertake a broader review of the literature on decentralisation, focusing not only on fiscal decentralisation, but on the evidence relating decentralisation to a wide range of inputs, processes and outcomes, in particular: health outcomes, process measures, humanity, equity, staff morale, responsiveness and allocative efficiency, technical efficiency, adherence to performance targets and accountability. A detailed summary of their findings is set out in Appendix 1. They then reach conclusions about the quality of the evidence and its relevance to the English National Health Service. Overall, they conclude that:

- Although there is evidence of positive relationships between decentralisation and health outcomes, the evidence for the English NHS is weak. They argue that existing analyses tend to use rather crude measures of decentralisation, and that as the evidence is mostly from low-to-middle income countries, which does not necessarily apply to the English NHS, or from countries such as Canada which organises its health care system in different ways from the English NHS, we

cannot be sure that an increase in decentralisation in the English NHS would lead to overall improvements in health.

- Evidence in relation to process measures is equivocal – The focus here is on: flexibility in meeting service user needs, responsiveness and effectiveness arising from increased local knowledge about what is actually going on; innovation, morale and productivity; co-operation and communication; and issues relating to economies of scale and scope. Peckham *et al* conclude there is no real definitive evidence on this point, except perhaps in relation to decentralisation improving staff morale (see below, in relation to staff morale). They also note that there is a continuing debate in the literature about whether there are economies of scale which can be exploited in order to improve efficiency, which would favour less decentralisation at times; however, they later note (see below, in relation to technical efficiency) that the literature on size of organisation and its relationship to performance is seen to be equivocal, with size suggested as only one factor involved in determining performance.
- Evidence in relation to humanity supports decentralisation to some degree – This concerns promoting the wellbeing of local populations, being accountable to local needs, treating staff well and enhancing civic participation. Peckham *et al* find that assessing the evidence on the impact of decentralisation on humanity is complicated by a lack of clarity around the concept. However, they note the importance of autonomy to promoting trust and of trust to enhancing performance; they report there is some evidence that decentralised agencies are seen as closer to their local communities, and that local boards feel responsible to those communities; and they report evidence of enhanced worker empowerment arising from decentralisation. These findings are tempered, however, by concerns over majority groups dominating decision-making, although it is noted that when minorities work together nationally, they may have a more powerful voice.
- Evidence in relation to equity is scarce, and the literature is not always clear about which form of equity it is concerned with. Peckham *et al* report that the evidence suggests decentralisation is associated with increased inequities in access across regions, but perhaps improved equity through better responsiveness within

regions. They also point to a lack of evidence that centralisation promotes equity and that equitable service delivery is in fact very difficult to attain in practice.

- Evidence in relation to staff morale is also equivocal – with some contradictory evidence, limited evidence in health, and concerns that other factors may be more important than decentralisation *per se*.
- Evidence in relation to responsiveness and allocative efficiency is seen to be fairly weak – This concerns patient-level outcomes such as patient participation in decisions, prompt attention and clarity of communication, along with access to social support networks, family and community involvement, and choice of provider. It also covers appropriately meeting needs and providing the quantity and type of health services desired by society. Peckham *et al* find some supporting evidence that decentralisation improves responsiveness to patients and local communities, but they also note there is no evidence that either decentralisation or centralisation is better at promoting innovation and no evidence that it is decentralisation that leads to an increasing focus on patient-centred care.
- Evidence in relation to adherence to performance targets and evidence-based protocols is also seen to be equivocal. Here it is noted that, with decentralisation, some form of centralisation is usually retained, and staff may continue to operate as if there are central controls if this is what they are used to. Some evidence points to the importance of trust in relation to performance in professional organisations and concerns over organisational capacity to promote adherence.
- Evidence in relation to technical efficiency (maximising outputs for the inputs used in service delivery) – Peckham *et al* report there is evidence that decentralisation may reduce costs through better resource use and where there is competition. These improvements would need to be set against losses associated with a lack of economies of scale and higher transaction costs in decentralised systems, but the literature on size of organisation and its relationship to performance is seen to be equivocal, with size suggested as only one factor involved in determining performance.

- Evidence in relation to accountability (being held to account and transparency) is also seen to be fairly weak, and contradictory – with some evidence of a focus on local accountability at a local level through a decentralised approach, although reforms often also increase central accountability.

In drawing overall conclusions for the English NHS, Peckham *et al* note that the evidence base is very diverse, and only loosely connected to organisational performance. They also note that the context of decentralisation is important, affecting the relevance of the evidence to particular contexts and hence potentially limiting transferability from one setting to another. Finally, they suggest there is a need to be clear about the weighting that should be applied to policy goals, before decisions can be made about whether decentralisation is an appropriate policy for any particular setting.

Wyss and Lorenz discuss the experience of Switzerland, which has a highly decentralised health care system (with a Confederation, 26 cantons and 3000 municipalities for a population of around 7.25 million). Cantons organise the provision of health care for defined geographical areas, with populations ranging in size from 35,000 to 1.2 million people. Cantons are responsible for many health service planning responsibilities. Wyss and Lorenz suggest that the independence of each canton is such that there are 26 comprehensive health care delivery systems operating in Switzerland. The cantons have, however, established inter-cantonal responsibilities, in relation to co-ordination, medicines and training of paramedical and auxiliary staff. Some cantons also work together to integrate hospital resources and referrals, and to organise specialised services (such as heart or kidney transplantation). Wyss and Lorenz note that these arrangements do not always work well, and voters in cantons can and often do vote to overturn proposals for reforms which would mean giving up local services. Sickness funds also require people to seek care in the cantons in which they live. The result is that expensive hospital facilities are sometimes available close together. There are also arrangements for funding cross-cantonal flows of patients and finances. In relation to efficiency, Wyss and Lorenz point out that there are a high number of physicians and hospital beds, and a large amount of sophisticated technical equipment and treatments. The authors

argue that the lack of federal planning means that it is difficult to co-ordinate and organise cutbacks in the number of hospital beds and physicians.

Wyss and Lorenz also point out the inequities that occur as a result of the Swiss arrangements. It is up to each canton to determine the conditions of access to financial assistance, and there are therefore differences in how cantons approach this task. The distribution of staff and facilities also differs significantly across the cantons, although some of this is due to the inter-cantonal agreements for provision of care. Finally, as federal contributions for health care funding reach only around 15%, there is also significant difference in expenditure across the country, and the contributions that individuals make through insurance premiums also differ widely.

The authors conclude that although decentralisation may allow responsiveness at a local level, the case of Switzerland shows the impact of a highly decentralised system, where financing especially is the responsibility of local governments. Health policy and strategy and health reforms are therefore difficult to achieve.

Saltman and Bankauskaite (Saltman and Bankauskaite 2006) usefully summarise more recent experience in relation to decentralisation in Western European countries. They note that decentralisation in political terms has become common in recent years in European tax-funded health systems. Usually, however, decentralisation occurs by focusing on specific areas of decision-making, with policy making a shared exercise, and regional and local decision-makers making a wide range of service-related decisions. Key strategic levers and regulatory power remain a central government responsibility. Saltman and Bankauskaite also note that the balance of decision-making generally shifts over time between the various layers of government. They refer to the shifting of responsibilities for hospital services between national and regional levels in Norway, with increasing concerns over time related to the inability of the regional agencies to keep with agreed budgets, and on-going demands for increased funds (European Observatory 2000). Recentralisation occurred in 2002, shifting to the concept of hospitals as a public firm, but in 2006, began to consider how to include some form of local democratic control (Johnsen 2006). Saltman and Bankauskaite note similar issues in relation to the experience of Finland, but reforms in 1992 giving municipalities policy-making responsibility for primary and hospital

care have more recently given way to concerns over waiting lists for elective procedures and concerns over indications of inequalities for patients living in different hospital districts. This has led to consideration of whether there should be more central control over hospitals in Finland.

Saltman and Bankauskaite go on to note the forms of administrative decentralisation in Sweden, Denmark, Finland, Spain and Italy. They note the use of new management tools, usually drawing on 'new public management' approaches, adapted for health (Saltman and Bankauskaite 2006). This includes public hospitals being developed into independently managed semi-autonomous organisations, or through purchaser-provider split arrangements, of various forms in England, Sweden, Basque Country, Andalucia, Catalonia, Norway, Italy, and Portugal. It also includes a variety of public-private partnerships – agreements between public purchasers and private providers to deliver services (eg, for elective surgery in order to reduce waiting lists) or private financing arrangements for capital developments.

In relation to fiscal decentralisation, Saltman and Bankauskaite note the general reluctance of national governments to undertake fiscal decentralisation. In Europe, Swedish county councils raise 70% of their revenue from county-level taxes, with the remainder from a variety of state sources. Similar arrangements apply in Denmark, although in 2007 fiscal decisions will shift to the national government with administrative responsibilities in the hands of five new, larger regional entities. In Finland, funding responsibility was split 50-50 between national and municipal sources up until 1992, while also retaining control over personnel appointments and large capital investments. The experience in Spain is for there to be 'fierce struggles' (Saltman and Bankauskaite 2006) over fiscal decentralisation, with considerable decentralisation (through passing funds to regions with few controls and also enabling additional fund raising) in the 2000s and major concerns in 2005 over deficits in some regions. Italy has similar arrangements and disputes, with regions concerns about under-funding and many running considerable deficits. Thus, the split of national funding from regional administrative responsibility is seen to separate financial accountability from operating accountability, with the result that there are 'pitched political battles between central and regional governments over the total amount to be distributed as well as allocation formula among the differing regions' (Saltman and

Bankauskaite 2006). However, Saltman and Bankauskaite also note that there are advocates who suggest that there are differing service delivery strategies developing in more innovative regions, which are argued to be a more important legacy. Saltman and Bankauskaite also note the variety of fiscal equalisation policies designed to even funding between poorer and richer regions, which also lead to disputes between national and regional governments.

Decentralisation has also been an important issue in Canadian health care policy over the past two decades; sometimes labelled 'regionalisation'. Flood and Sinclair (2005) argue that, in Canada, devolution to provincial and local governments and has much to offer over centralisation to the federal government, in particular arising from locating responsibility for the management of health close to the people who are served by the services, and by forcing provincial governments to provide leadership. They argue that devolution in Canada has show some successes and some failures, with the failures relating to devolution not occurring in practice, as not all services have been devolved, and line-by-line budgets have often continued to be set at a provincial level, leaving little latitude at a local level. Flood and Sinclair report stronger accountability frameworks in Alberta and British Columbia at health authority level as a result of devolution, with a greater distinction between governance and management.

Lewis and Kouri (2004) provide a recent report on regionalisation in Canada. They note that regionalisation has taken different forms in different Canadian provinces, but that there are similarities in that (other than in Ontario) regions are defined by geography; they are devolved authorities established by provincial governments; they consolidated authority and programmes which were previously fragmented; and the range of services they are responsible for is broad. The models are generally regarded as building on population health and local community governance perspectives, and as well as devolving authority within provinces, generally also consolidated authority by amalgamating many separate smaller authorities (for example, prior to regionalisation Saskatchewan had 435 health boards for a population of 1 million).

Lewis and Kouri report that regionalisation has not been fully implemented, with little stability in the system over the past decade, constraints on ability to make decisions, and different models in place in the different provinces (for example, in some cases regional CEOs are appointed by provincial Ministries of Health and are wholly or partly accountable to them). Not all services were devolved, with physician services and medicines kept outside the jurisdiction of regional authorities.

Some gains are reported as arising from decentralisation in Canada – including less fragmentation, a greater focus on the whole system of health care, improved inter-sectoral partnerships, and an increased focus on primary health care. On the other hand, Lewis and Kouri also note a number of new problems that emerged as a result of regionalisation, with consolidation reducing the sense of ownership at a local level, and resulted in some disenfranchising of citizens also at a local level. The establishment of community boards within higher level authorities created further tensions at times, and made it difficult for the higher level authorities to earn loyalty and respect at a local level. Difficulties have also arisen in relation to accountability, with citizens holding provincial governments they know well accountable for health care as opposed to regional health authorities which are still fairly new in some cases.

Overall, the international literature shows that decentralisation, and research into the effects of decentralisation, is a complex topic. It suggests that the context in which decentralisation occurs, and the way in which decentralisation is organised, will be key factors in how a decentralised system performs. The main issues which arise where countries are moving towards decentralisation or devolution relates to the actual balance of decentralised and central decision-making that develops in practice, and to how central government guidance and monitoring on decision-making impacts at a local level. The literature suggests that often a degree of both increased decentralisation and increased centralisation can occur at the same time.

The literature also finds there is limited evidence of the impact of decentralisation on key policy goals, and much of the evidence is seen to be equivocal. The evidence does suggest that there may be a positive relationship between decentralisation and health outcomes, but there remain concerns over the measures used and the findings may not necessarily apply in New Zealand. The evidence also offers some support that

decentralisation (and autonomy) may promote trust and that decentralised agencies are seen to be closer to their local communities and may promote equity of access within regions, as decentralised agencies are more responsive to local needs. There is also some evidence that decentralisation may reduce costs through better resource use and where there is competition. On the other hand, there are concerns over majority groups dominating decision-making and over the potential for a decentralised system to lead to increasing inequities across regions. There also remain concerns over whether decentralisation results in missing opportunities to benefit from economies of scale, but the evidence on the relationship between the size of an organisation and its performance is seen to be equivocal, with size suggested as only one factor involved in determining performance. Thus, the literature suggests that key trade-offs may occur between achieving a degree of equity (of access) across districts and economies of scale on the one hand (suggesting larger organisations and less decentralisation), and responsiveness, local accountability, technical efficiency and equity within districts on the other (suggesting greater degrees of decentralisation).

2.3 Analysing Decentralisation in New Zealand

As can be seen from the above discussion, analysing issues relating to decentralisation is complex. Countries are likely to have a mix of functions allocated centrally as well as a degree of decentralisation via deconcentration, devolution, delegation and privatisation of some functions. Furthermore, there are a range of services covered by the health sector and different degrees of decentralisation may exist at any one time for different services. In the New Zealand health and disability sector, the range of services provided include: primary health care and referred services (pharmaceuticals and laboratories), secondary and tertiary medical and surgical care (usually delivered in hospitals), mental health care, maternity and child health services, dental health services, disability support services, rehabilitation services, care of the elderly services, and public health services. Differing degrees of decentralisation can operate with each type of service. A further complication relates to the ways in which services are organised around institutions, again with differing degrees of decentralisation possible. Key institutions in New Zealand currently include publicly-owned hospitals; privately-owned not-for-profit and for-profit hospitals; general practices, general

practice networks, pharmacies, laboratories, rest homes, dental clinics; and community-based organisations, such as primary health organisations (PHOs), iwi-based services and not-for-profit organisations such as Plunket, CCS and IHC.

In New Zealand, legislating, revenue-raising and policy-making functions are currently undertaken by central government, involving a single national policy agency, the Ministry of Health. In primary care, the Social Security Act 1938 saw the introduction of government subsidies through the 1940s. For hospital care, local authorities historically had a significant role to play in funding such care, but revenue-raising became a central government function fully in the late 1950s (Hay 1989).

Also in New Zealand, regulation functions have usually been established nationally in health care, although some functions are delegated (for example, registration of medical professions is 'privatised', being the responsibility of health professional councils, although enabled by central government through legislative provisions).

In New Zealand, it is the planning and resource allocation and management functions which have undergone change over time during successive reforms of the sector, and which are the key focus of this research.

New Zealand has a history of many health services – including hospital services – being organised at a local level (Brunton 1983), with early central government responsibility for asylums, sanatoria, and maternity care (Malcolm 1990). Malcolm (Malcolm 1990) has noted that since then, '*the historical development of the health system has been characterized by the gradual growth of central government, and the assumption of greater central responsibilities, including funding*' (Malcolm 1990).

The main changes have been around the role of hospital boards in New Zealand, and how they link with the broader health care system. Twelve hospital boards were originally proposed in 1885, but by 1925, there were 47 hospital boards, governed by locally elected Boards. Broadly speaking, the system has undergone four major waves of reforms since this time.

The first set of reforms, which took place prior to the 1970s/1980s, involved a lessening of decentralisation with the amalgamation of hospital boards over time. By 1985, the number of hospital boards had fallen to 29, with populations ranging in size from 2790 in the Maniototo to 894,000 in Auckland (Malcolm 1990). Responsibility for primary health care funding was, as it always had been, the responsibility of a central Department of Health. Public health services were also the responsibility of the Department of Health, with regional offices of health (a form of deconcentration). Responsibility for some community-based services also lay with the Department of Health (eg, Plunket). Disability support services were the responsibility of the central Department of Social Welfare.

The second set of reforms, which took place during the 1980s, involved the devolution of public health functions from central government to area health boards (AHBs) at the same time as decentralisation lessened with the amalgamation of 27 hospital boards into 14 area health boards, during the 1980s. These reforms can be seen as a way of promoting a greater degree of strategic planning for a population's health at a local level, while also broadening the responsibilities of local health organisations to encompass a wide range of health services. AHBs came to be governed by majority elected Boards, with central government appointing some members to these Boards in the late 1980s. Funding for primary care and for community care, however, remained the responsibility of the Department of Health. Although this model was seen as an important step towards improved integration of planning across many services and for promoting community participation (Guald 2001), there were on-going concerns related to lack of integration of funding for primary and secondary care, and poor incentives for promoting efficiency and responsiveness (Health Benefits Review 1986; Hospital and Related Services Taskforce 1988; Guald 2001). During this time, central government also began to establish a set of goals for AHBs to work towards. The first set of contracts between central government and local health boards were also introduced in the late 1980s, aimed at increasing accountability of local boards to central government.

The third set of reforms took place during the 1990s, with a shift away from participatory approaches to managing health care towards more market approaches, based on a 'quasi' market model. This approach aimed to promote a strong

purchasing role, with competition between providers for funding designed to promote efficiency and responsiveness (Ashton 1993; Cumming and Mays 2002). The reforms involved devolution of primary health and disability support services from a central Department of Health to four Regional Health Authorities (RHAs); or regionalisation of planning functions from fourteen AHBs to four RHAs; devolution of hospital management from fourteen AHBs to 23 Crown health enterprises (CHEs); and centralisation of public health planning to a Public Health Commission (PHC), in 1993 (followed by devolution of these functions to the four RHAs in late 1995). The new organisations in the sector – RHAs, PHC, and CHEs – were all governed by Boards appointed by central government. In 1998, there was a centralisation of the planning functions from four RHAs to one, single, national Health Funding Authority (HFA) (with a degree of deconcentration, as the HFA maintained regional offices in Auckland, Hamilton, Christchurch and Dunedin as well as its head office in Wellington). The 23 CHEs became known as Hospital and Health Services (HHSs) at the same time, with a return to a more collaborative and community-focused approach. The ‘quasi’-market model was very unpopular throughout the 1990s, and although there were some positive changes resulting from the reforms (for example, in encouraging the development of greater diversity in provision of services, including through by Māori for Māori services, and in encouraging the development of networks of GPs), the reforms were regarded as generally not having achieved the efficiency gains promoted by those establishing the ‘quasi’-market model (Cumming and Salmond 1998; Devlin and O’Dea 1998; Ashton 1999). At the same time, within particular services, a degree of privatisation occurred – with care of the elderly and mental health services in particular increasingly provided by private providers (services also shifted from institutions and hospitals to the community).

The fourth major set of reforms involved the establishment of the NZPHDA model in 2001. This model can broadly be described as a form of devolution of planning and resource allocation functions, given the allocation of these functions from a single, national health funding authority (the HFA) to 21 geographically-based DHBs. DHB organisations are governed by a mix of elected and appointed members (elected members being the majority). In implementing the model, the purchasing functions of the HFA were first transferred to the Ministry of Health, and a formal process of

devolution to DHBs then occurred. Devolution of responsibility for decision-making would generally follow devolution of funding to DHBs. The following sections of this report focus on devolution in practice within the NZPHDA model.

3 Health Reforms 2001 Research

3.1 Framework for Analysis

This research report approaches considers the following issues in relation to devolution:

- What were the *intentions* of the model around devolution?
- What have been stakeholders' *experiences* with the model – What has happened in relation to devolution of funding and devolution of decision-making? What are the advantages and disadvantages of the current arrangements? The research focuses in particular on:
 - Local vs regional vs central funding and decision-making
 - *A local focus* – meeting local needs, local prioritisation, integration, innovation, community participation)
 - *Efficiency* – economies of scale, duplication/fragmentation; linked to number of DHBs
 - *Capacity and capability issues* – DHBs having capacity and capability to undertake key tasks
 - *Collaboration* – DHBs working together to overcome disadvantages
 - Central government roles – in terms of strategies and planning, and monitoring via various accountability arrangements (performance management, incentives/sanctions)
 - Adaptation of the role of the Ministry of Health – with respect to devolution.
- How can the model be *improved* with respect to devolution?

One issue not considered here relates to fiscal discipline and whether a decentralised model may lead to reduced fiscal discipline, where local agencies, not responsible for raising funds for health care, over-spend or focus on calling for greater funds from central government, rather than managing within budgets. This is considered in a separate report (Synthesis report). Issues relating to the experience of Māori and Pacific Peoples are also included in a separate report.

3.2 Research Methodology and Methods

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

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

- Public telephone survey (Mid-2001)
 - A telephone survey was carried out by BRC Marketing & Social Research. A random sample was taken of New Zealanders listed on the General Electoral Roll, and Māori were selected in a booster sample using the Māori Electoral Roll. The response rate was 40% (39% for non-Māori, 44% for Māori). The fifteen minute telephone survey of 504 New Zealand citizens, including 95 Māori, was conducted in June-July 2001, at the beginning of the reform process.
- Document analysis (On-going)
 - Documents from 20 participating DHBs were analysed including: health needs assessments, district strategic plans, district annual plans, statements of intent, annual reports, financial reports and other material as relevant.
 - In addition relevant Ministry documents and cabinet papers were analysed.
- Key informant interviews (2002, 2004/5)
 - Nineteen interviews were conducted with seventeen key informants in 2002, including ministers, officials, coalition government spokespeople on health, opposition spokespeople on health. Separate key informant interviews were held

with Māori and Pacific ministers, officials, and national commentators on health. The aim of the interviews was to identify the goals and expectations of the reformed model, to identify key issues expected to arise from the model and to discuss early experiences with the model. In 2004/05, a further 12 key informant interviews were undertaken with government Ministers and senior officials in the Ministry of Health.

- Postal questionnaires to DHB Board members (2002, 2004)
 - Postal questionnaires were sent out to all Board members in 2002 in 20 participating DHBs and to Board members in 21 DHBs in 2004. The 2002 questionnaire went to 217 Board members and had a response rate of 66%; varying from 45% to 82% across DHBs. The 2004 questionnaire went to 221 DHB Board members, with a response rate of 61%, ranging from 36% to 82% across DHBs. Two approaches were used to collecting data. First, Likert scales were used, where respondents noted if they strongly disagreed, disagreed, neither disagreed nor agreed, agreed or strongly agreed with statements relating to key topics of the research. Second, questions allowing ‘free text’ responses were used.

- Interviews with DHB Chairs and CEOs (2002/03, 2003/2004)
 - A small number of DHB Chair interviews took place in 2002/03, with a further 14 interviewed in 2004. Eighteen CEOs were interviewed in 2002/03 and 20 were interviewed in 2003/04.

- Interviews with Planning and Funding Managers (2002)
 - These focused on experiences of the needs assessment and prioritisation processes used by DHBs in 2001/2002.

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

The research in the case study districts involved (2002, 2004/5):

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

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

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

3.3 Data Analysis

Interviews and documents were analysed by a process of thematic analysis (Patton 2002; Bowling and Ebrahim 2005). All transcripts were entered into an NVivo database. Themes for analyse were agreed by the research team. Transcripts were coded by theme, with the data being separated out into themes and sub-coded. Themes were then compared across interviews by one member of the research team and written up. Documents were also being analysed using similar thematic analysis techniques.

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

Document analysis and observational techniques were used in triangulation with information from interviews and from the Board member survey, i.e. to identify whether key activities and actions discussed in interviews were supported by documentation.

4 Research Findings

4.1 Findings – The NZPHDA Model and Devolution – Intentions

4.1.1 Cabinet Papers

Analyses of documents from the early 2000s show a clear desire for a system focused on improving health and independence and reducing disparities, including a focus on communities and local input into decision-making. A population health focus was key; and communities would have input into DHBs through elected representation on DHBs and through assessments of local health needs (King 2000a).

An early paper noted that the Government wished to develop a structure that *inter alia*, ‘*devolves responsibility for local planning and funding to DHBs, who understand and can best represent the needs of their local community*’, while the Government has the task of determining the level and allocation of funding to DHBs and provides a ‘*national policy and accountability framework with guidelines within which DHBs have flexibility to provide and/or fund services for their populations*’ (King no date-a). This same paper also draws attention to the need to ‘*get the balance right*’ (King no date-a) between empowering DHBs to make their own decisions and ensuring nationwide consistency and equity of access to services; and DHBs then will ‘*have a degree of autonomy, but they will be required to operate within the bounds of the Government’s NZHS and the accountability arrangements with the Crown*’ (King no date-a). In a second paper, it was noted that ‘*DHBs will be responsible for deciding on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, NZ Disability Strategy and nationwide minimum service coverage and minimum quality standards...*’ and that ‘*DHBs will evolve towards maximum autonomy as they become capable*’ (King no date-e).

A number of Cabinet papers also focused on issues relating to devolution of funding and decision-making, along with issues relating to accountability. Early documentation relating to accountability under the NZPHDA model noted that DHBs ‘will be accountable to the Minister of Health’, although ‘elected members would also be answerable to their local community’ (King no date-e). Cabinet papers set out key principles and issues relating to devolution, canvassing issues relating to the advantages and disadvantages of DHBs having high and low degrees of autonomy in decision-making and the role of the Ministry of Health (King no date-e).

The impact of developing high degrees of autonomy included:

- tailoring services to local needs and preferences and improving co-ordination within districts; while also reducing the role of the Minister in relation to DHB decision-making and focusing that role on strategic issues;
- reducing the leverage the Minister of Health has on DHBs while also increasing the role and responsibility of the Board and the ability of the community to be involved in decisions;
- increasing DHB staff and infrastructure while reducing the size of the Ministry of Health;
- decreasing the likelihood of national consistency in who gets what services; and
- increasing co-ordination issues across districts (King no date-e), p. 4).

Risks could however be mitigated by continued development of nationwide minimum service coverage and quality standards; and the establishment of common services agencies or having the Ministry of Health carry out some analytical and contracting tasks.

Cabinet agreed in 2000 that DHBs will have ‘responsibilities for making decisions on the mix, level and quality of health and disability services, within the parameters of the New Zealand Health Strategy, Disability Strategy, and nationwide minimum service coverage and safety standards’ (King no date-e)p.10). DHBs were to work within a highly regulated and prescribed environment, which would then be ‘progressively relaxed as each DHB is progressed towards the maximum envisaged

degree of autonomy’ (King no date-e)p.10). Cabinet agreed that the Minister of Health’s role (assisted by the Ministry of Health) would be consistent with ‘high DHB autonomy (local decision-making within central parameters)’ (King no date-e)p.3), i.e to:

- Define strategic directions for the health and disability sector
- Define nationwide minimum service coverage and safety standards
- Define the operating environment
- Enter into funding agreements with DHBs containing the DHB-specific agreed performance targets
- Exercise reserve powers (King no date-e)p.11).

This set of functions left the definition of the detailed mix, level and quality of services DHBs will fund or provide outside of the role of the Ministry of Health. The Cabinet paper noted that in defining nationwide minimum service coverage and safety standards, that ‘the scope and detail of this service coverage will influence the degree of DHB freedom’ (King no date-e)p.4).

A later Cabinet paper focused on the ultimate division of roles between DHBs and the Ministry of Health. This paper recommended that apart from exceptions identified by the Government, DHBs were to be ultimately responsible for planning and funding all health and disability support services, in order to ensure that: DHBs have unambiguous accountability for ‘funding the best mix of health and disability support services...within budget’; local users and communities ‘have a greater say’; and that any conflict of interest between the Ministry of Health funding services and funding and monitoring DHBs ‘is minimised’ (King no date-d).

However, it was recognised that there may be reasons why some services ought not to be planned or funded by individual DHBs:

- regional or national organisations may face additional administration costs from multiple, complex contracts with many DHBs, and some services require much inter-district co-ordination;

- some small DHBs may find it difficult to manage within budgets when faced with exceptional or unpredictable high-cost services;
- parts of the disability sector feel that DHBs may not be appropriate funding agencies, because disability issues are different from health care, and DHBs may put low priority on disability support services;
- some small DHBs may find it difficult to plan for services that are rare or require specific expert knowledge;
- development in Māori, Pacific, and mental health, and in disability support, may be put at risk without national management (King no date-d).

A number of risks of removing funding responsibilities from DHBs were also noted:

- confusion about who is accountable for prioritisation and improving health and independence of DHB populations – the DHB or another agency;
- greater potential for cost-shifting between multiple funding streams, for example by redefining secondary services as tertiary services;
- a conflict of interest between the Ministry of Health funding services and funding and monitoring DHBs;
- barriers to local service coordination and integration;
- reduced responsiveness to local needs, preferences and opportunities (King no date-d).

It was suggested that ‘unintended consequences could include poorer decisions on service mix and levels, and budget overruns’(King no date-d). It was therefore recommended that as general principles:

- i. all health and disability services funding should be indicated to DHBs before allocation to any regional or national budget, to ensure DHBs are aware of which services they contribute to and their costs;
- ii. if services need to be planned or funded for at a regional or national level, then, as far as possible, such arrangements should keep DHBs accountable for performance (King no date-d).

In response to the issues raised in the Cabinet paper, Cabinet agreed that DHBs would ‘progressively move to the appropriate degree of devolved responsibility for planning and funding health and disability support services, as determined by the Government’ (King no date-d), and directed more work to be undertaken in relation to how responsibilities would be allocated and a timeframe for this.

Cabinet also agreed that:

- initially DHBs will be subject to strong central control – they may be responsible for only a limited range of services with the balance being funded directly by the Ministry of Health;
- additional responsibilities will transfer to DHBs as and when they have clearly demonstrated that they are capable of dealing with them;
- if a DHB’s performance is not good enough, it will not be allowed to expand its responsibilities, and if performance deteriorates the Government will be able to withdraw functions from DHBs and return them to the Ministry of Health;
- responsibility for funding some tertiary and quaternary hospital services, some disability support services, and some public health programmes and services delivered by national organisations will remain at the national level indefinitely (King no date-d).

Cabinet also noted that ‘there will be specific exceptions to the general principle that DHBs will ultimately have responsibility for planning and funding all health and disability support services; agreed that decisions on future arrangements for national screening programmes be made at a later date’ and agreed that ‘in future, DHBs will be advised of the PHARMAC forecast of expenditure for their population, but that each DHB will be responsible for managing their pharmaceutical expenditure within the whole population-based funding budget allocated to them, and they will be charged for the actual pharmaceutical expenditure of their population’ (King no date-b).

The Treasury comment on this particular Cabinet paper noted that it agreed with proposals that DHBs be responsible for services, with rare exceptions. Treasury felt, however, that the indeterminate transitional period during which the Ministry of Health rather than DHBs would have responsibility for some services had risks associated with it; in particular, likely difficulties in moving roles from the Ministry of Health, and it noted a desire for clear accountability processes that Ministry funding responsibilities are discharged separately from Ministry funding and performance functions in relation to DHBs (King no date-d).

In terms of governance of DHBs, it was an early decision that DHB Boards were to be accountable to the Minister of Health ‘for achieving health and disability outcomes for their populations’ (King no date-c), but it was recognised that the structure blends different forms of governance through having elected and appointed members; different forms of control through central and local mechanisms; and different forms of accountability, to communities and central Government. The dual accountabilities, particularly of elected members, to Ministers and the community which elected them, were noted as key issues, to be managed by ‘creating a strong accountability to the Minister of Health’ (King no date-c). The principle of collective responsibility for decisions was also noted as a key mechanism in managing potential conflicts.

In terms of accountability mechanisms, two main planning documents were to be developed for each DHB:

- a high-level Strategic Plan, ‘developed in consultation with the local community, and which sets out local goals, objectives, targets and strategies that are consistent with the New Zealand Health Strategy and New Zealand Disability Strategy...’. It was suggested that ‘Community consultation and an environmental analysis of health needs in the community will provide the basis for development of the Plan’ (King no date-b);
- an Annual Plan, which is the formal negotiated accountability document between the Board of the DHB and the Minister of Health. It is to set out outputs and associated performance expectations.

The New Zealand Health Strategy and New Zealand Disability Strategy are means by which the Government communicates its desired outcomes, and they are to ‘provide the overarching policy framework within which the health and disability sector will be expected to operate. These strategies will establish specific nationwide health and disability outcome goals, objectives and targets, and sector performance standards’ (King no date-b). Again, early documents suggested that these Strategies would ‘guide the delivery of services’, and provide a ‘context within which...DHBs are established’, over time DHBs will ‘develop specific goals relating to the health needs of their individual communities’ (King 2000c).

4.1.2 The NZPHD Bill and NZPHD Act

The NZPHD Bill was introduced into Parliament on 17 August 2000. The accompanying speech by the Minister of Health focused on, amongst other things:

- restoring community involvement in and ownership of health at a local level;
- the role of New Zealand Health and Disability Strategies guiding the sector in future years; allowing local communities to have input into DHBs through elected representation and through locally-conducted assessments of community health needs;
- noting, in relation to the new structure based on 21 DHBs and the Ministry of Health, that ‘DHBs will gradually assume responsibility for funding or providing services for geographically-defined populations and will be responsible for public hospitals and other related services’ (King 2000b) p. 1). Each DHB would be accountable, *inter alia*, for ensuring communities are involved in the Boards’ deliberations as much as possible, with Board meetings open to the public, and DHB performance information being publicly available;
- a number of accountability mechanisms, including a strategic plan, an annual plan and regular monthly and quarterly reports. Plans were to reflect the full range of services needed in each area, prudent management of Crown-owned assets, and include ‘specific initiatives or priorities communicated by the Minister’ (King 2000b).

The Bill's explanatory notes also focused on, amongst other things (New Zealand Government 2000b):

- removing the competitive model and replacing it with a co-operative and collaborative approach and addressing the distancing of communities from decision-making by strengthening local community input and ensuring a population health focus;
- noting that DHBs may deliver services themselves or arrange for other providers to do so; and the Ministry of Health will also have a role in planning and funding some services if significant national co-ordination or management is required. DHBs were expected to work together and enter into co-operative and collaborative arrangements where appropriate, to ensure the best service delivery for their populations;
- allowing for the Ministry of Health to initially take responsibility for existing service contracts, which will become the responsibility of DHBs as they become capable of assuming greater levels of responsibility;
- planning is to be consistent with the resources available to DHBs, and will be undertaken 'within the parameters of the New Zealand Health and Disability Strategies' (New Zealand Government 2000b)p. 5).

In later reporting the Bill back to Parliament following the Select Committee process, the Minister again noted that the NZ Health and Disability Strategies will 'provide guidance for DHBs and other health organisations on the achievement of health objectives and priorities' (King 2000d).

In the third reading, the focus was on:

- putting the word public back into the health service, in order to improve health; on reducing disparities which requires a long-term collaborative approach, that involves 'empowering communities to make decisions about the health needs of their own people';

- charging DHBs with leading the population approach to health care. The NZ Health Strategy would provide a framework for improving the health of people and communities. DHBs will be required to ‘take account’ of the strategies in developing their strategic and their annual plans;
- an open and accountability public health service people could trust. ‘The Bill is, in effect, an empowering Bill. It empowers health professionals, and it empowers New Zealand communities’ (King 2000e).

The legislation was passed on 7 December 2000, coming into force on 1 January 2001. Key requirements in the legislation relevant to issues of devolution are summarised below:

- Under the Act, the Minister of Health is responsible for determining a strategy for health services, (s.8); and the Minister responsible for disability issues must determine a strategy for disability support services (the New Zealand Health Strategy or NZHS and the New Zealand Disability Strategy or NZDS).
- DHBs are established as statutory corporations¹. They have a number of objectives, as defined in the Act (s.22), to (*inter alia*) improve, promote and protect the health of people and communities; promote effective care or support for those in need of personal health services or disability support services; promote the inclusion and participation in society and independence of people with disabilities; reduce health disparities by improving health outcomes for Māori and other population groups; and reduce, with a view to eliminating, health outcome disparities between various population groups.

¹ The Crown Entities Act 2004 provided for DHBs to become crown agents, statutory Crown entities that have a close working relationship with the government of the day. For further information, see <http://www.ssc.govt.nz/display/document.asp?navid=230>

- DHBs are to foster community participation in health improvement and in planning for the provision of services. DHBs are clearly accountable to the Minister of Health (s. 37). They must develop district strategic plans (DSPs), district annual plans (DAPs) and table statements of intent in Parliament. DSPs must reflect the overall direction set out in, and not be inconsistent with, the NZHS and the NZDS (s.38 (7)).
- Crown Funding Agreements (s. 10(1)) also enable the Crown to monitor performance (s.10(2c)). This monitoring is delegated to the Ministry (s.10(3)) (New Zealand Government 2000a).

4.1.3 The Views of Key Informants

Key informant interviews undertaken in the first round of data collection also focused on issues relating to devolution. In relation to the goals of the reforms, some informants felt that, in addition to improving population health and reducing inequalities, devolution and community participation were key ends in themselves. Thus, the reforms were in part aimed at changing the way in which the health system was governed and how decisions were taken, by ensuring that local populations are involved in those decision-making processes (Cumming, Goodhead et al. 2003). Local engagement was seen as important for getting things done, and for local communities to have greater confidence in prioritisation processes that occur at a local level (Cumming, Goodhead et al. 2003, p. 140). Some key informants felt that the main principle underlying the model was to be different from what was there before, with one important difference being that the RHAs had a large region to cover, while DHBs would be closer to their communities (Cumming 2006), p. 9).

At the same time, it was noted frequently that DHBs are clearly accountable to the Minister of Health. A contrast was made between local government boards (such as local councils), and DHBs, which are established to ‘implement the government of the day’s health strategy’ (KII 2, R1) (Cumming, Goodhead et al. 2003, p. 143). Some key informants pointed to the fact that funding for health is raised by central government as a reason why central government should play a key role in decision-

making in health. Other key informants noted that local DHB board members are there to bring local knowledge to decision-making processes, with one suggesting that DHBs can in fact make their minds up about a large number of issues (Cumming, Goodhead et al. 2003, p. 143).

Ministers and officials stressed that devolution of responsibilities to DHBs is to occur 'within the national frameworks' (Cumming, Goodhead et al. 2003, p. 96). Some officials noted that there is a tension between devolution and the national consistency promoted by the national strategies and the service coverage frameworks. This was seen as a paradox of the model and some suggested that this could be reflected at the local level by frustration at the lack of freedom for real local leadership (Cumming, Goodhead et al. 2003, p. 96).

Two other key informants felt the structure is set up so the Minister of Health can pass on responsibility to DHBs and let them become 'fall guys for drastic cuts' (KII 3, R1) (Cumming, Goodhead et al. 2003, p. 144). Another key informant raised a further concern around the accountability arrangements; suggesting that if DHBs did not have a reasonable scope of budget and responsibility for a reasonable range of service, then it would be impossible to hold them to account for anything as DHBs would simply be able to argue that what they were doing was influenced by a whole range of constraints. This key informant noted that if New Zealand was going this far to develop a devolved model, then we should go the whole hog and devolve [total] responsibility to DHBs. One official noted that the government was told that it would be making life difficult for itself by having strong local governance and strong upward accountability and no local funding of health care. Both local funding options and a local council model were however clearly not acceptable as solutions to these potential problems (Cumming, Goodhead et al. 2003, p. 145).

However, Ministers and officials also indicated that devolution was planned as an evolutionary process, as DHBs demonstrate capability. In part this reflected the importance of health to central government, and the political risk of 'getting it wrong'. It also reflected the size and resources of the Ministry, which may overshadow an individual DHB (Cumming, Goodhead et al. 2003, p. 96).

A key issue relating to devolution concerns the number of DHBs. In the Interim Report, we asked key informants to discuss the rationale for 21 DHBs. There were mixed views on this. Ministers, ministerial advisors and some officials noted a preference for focusing on issues relating to promoting *health* rather than wasting time engaging in arguments over the number and location of DHBs. Some officials felt moving from existing CHEs to 21 DHBs was a simple way of keeping the financial costs of implementing the new system down as far as possible; expanding the existing hospital management role rather than establishing a new organisation. Some noted that, from a policy perspective, there is a trade-off between obtaining economies of scale and managing risk in order to manage within a budget, favouring larger DHBs, against the closeness of DHBs to a local population, favouring smaller DHBs. New Zealand's social geography was seen as an important issue here, with many geographical boundaries leading to natural communities of interest. Some officials felt the establishment of 21 DHBs was a return to the previous model of hospital boards and AHBs, both of which were based around hospitals. Some suggested this reflected a deep-seated view that hospitals are central to the health care system in New Zealand.

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

Others noted that in addition to encouraging a smoother transition, establishing 21 DHBs and enabling voluntary amalgamations over time was a more sensible approach. Economies of scale could then be encouraged through co-operation between DHBs (and such co-operation would be beneficial in itself) (Cumming, Goodhead et al. 2003, pp. 25-26).

4.2 Findings – Early Experiences with the Model

4.2.1 A Local Focus

4.2.1.1 Support for a Local Model

In this research, we have found strong support for the local focus that the NZPHDA model was to embrace, and hence strong support for a devolved model of funding and decision-making. Support for a local focus has come through each stream of the research.

Support for the model is seen firstly in the Public Survey undertaken in 2003, where those New Zealanders surveyed indicated support for the model. Many of those surveyed agreed or strongly agreed that DHBs would take more notice of what New Zealanders think. Key activities for DHBs included setting budgets, deciding what services should be available, and consulting the public. Over 90% of respondents thought it important or very important for DHBs and other health care professionals to consult the public, particularly in relation to development of new services, closing down services, location of services and how services are paid for. Seventy-five percent of New Zealanders surveyed wished to have a say by voting for DHB members, although those surveyed did also see health professionals as key decision-makers.

In the first round of data collection, DHB CEOs saw the strengths being that the system brings funding together locally, and that the community is involved in planning and decision-making, allowing both responsive services and management of expectations (Cumming, Goodhead et al. 2003, p. 109). CEOs overall saw more strengths than weaknesses with the model, with most of the weaknesses being seen as manageable; irritations rather than features that seriously undermine the system. Major change was not recommended, and many CEOs anticipated improvements over time (Cumming, Goodhead et al. 2003, p. 197).

Those interviewed in the case study research in the first round of data collection also noted a number of key strengths:

- the ability to look regionally at the needs of the population
- the ability to involve community in decision-making
- the opportunity to be more locally responsive; in particular for the opportunity for better local planning and better local relationships
- the ability to plan more effectively for the local population
- enhanced engagement with providers at the local level
- increased transparency promoting more honest public expectations (Cumming, Goodhead et al. 2003, p. 110).

Interviews with national stakeholders in the first round of data collection similarly indicated support for a local model. NGO informants approved of community input, transparency and the emphasis on co-operation, local relationships, the building of local knowledge, greater flexibility of services, more innovation, opportunities to develop a shared vision and more direct accountability to the community. Some were optimistic about the future, noting there was an *'enormous amount of goodwill and people wanting to make it work'*.

4.2.1.2 Weaknesses of a Local Model

In the early stages of the model and the research, many of those we interviewed also pointed to some expected weaknesses in the model. Key weaknesses relating to accountability, the number of DHBs, capability and capacity are set out here; a further identified key weakness is that of higher than desirable levels of central control, which is discussed in more detail in sections on Devolution, below.

Accountability

One key issue related to the mix of accountabilities perceived in the model. Ministers and senior officials noted that under the NZPHDA, DHB Boards are formally accountable to the Minister of Health. The model, however, also includes local elections which appear to some to mean that DHB Boards are accountable to their local communities. As we noted above, this issue was predicted by some key informants to bring a degree of tension into the model.

The issue of perceived accountabilities within the NZPHDA model was canvassed in the Board member survey, sent to all Board members in 2002. The survey results show there were mixed views about accountability amongst DHB Board members, and their ability to handle ‘dual accountability’. In response to a statement ‘that the Board sees its primary accountability as to the government, not the local community’, just under half – forty-four percent – gave some level of agreement. Thirty-four percent of respondents neither agreed nor disagreed with the statement, while twenty-two percent gave some level of disagreement to the statement (c). Just over half (56%) of elected DHB Board members agreed or strongly agreed that they ‘feel able to handle the dual accountability to my community and the Minister of Health’, while a quarter neither disagreed nor agreed, and 20% disagreed or strongly disagreed they were able to handle the dual accountability (k). Māori respondents were more likely to feel able to handle the dual accountability to their community and the Minister of Health. A question was also asked of appointed DHB Board members, whether they ‘feel principally accountable to the Minister of Health’. Over half (58%) agreed or strongly agreed that they feel principally accountable to the Minister of Health. Twenty-three percent neither disagreed nor agreed, while 19% disagreed or strongly disagreed (l). In response to a question asking Māori DHB Board members whether ‘my accountability to whānau/hapū/iwi is a source of personal tension for me’, half disagreed at some level that as a Māori Board member, their accountability to whānau/hapū/iwi is a source of personal tension for them. Nineteen percent neither disagreed nor agreed, while 31% agreed or strongly agreed (m).

There were some specific concerns raised by CEOs about elected members having a strong sense of accountability to the community, with many '*struggling*' to see their primary accountability to the Minister. A number of strategies for dealing with this had been developed, however (Cumming, Goodhead et al. 2003, p.37). Similarly, data from the case studies showed some similar tensions on DHB Boards. In one case study DHB, there was a perception that business decisions may be less robust with elected members, as they tend to be '*clouded by more emotion*' than when there is a totally appointed Board. Appointed Board members tended to ask '*what is good for the organisation*', whereas there could be more emotion in decision-making with an elected Board. In another DHB, it was noted that some elected Board members tend to have a narrow focus on particular services rather than a broader strategic perspective (Cumming, Goodhead et al. 2003, pp. 39-40). In another DHB, informants acknowledged accountability to central government but saw accountability to the local community as more of a moral imperative, with at least one informant seeing their primary responsibility being to the community.

Number of DHBs

It was commented frequently through the research that there were perhaps too many DHBs. CEOs saw the transaction costs associated with a large number of DHBs as a key weakness of the model. Similarly, in the case study research, frequent comments were made in most districts suggesting that there are too many DHBs, too much duplication of effort and too many boundaries. Amalgamations or rationalisation were seen as almost inevitable. In one case study district it was noted that services could be planned in an ad hoc way and possible duplication could occur with each DHB doing their own thing. Thus, regional ownership and collaboration were seen as important. National stakeholder informants also raised concerns about there being too many DHBs. NGO informants suggested that this meant administrative costs are too high, with capacity and expertise split to an undesirable extent (Goodhead 2006), p. 56).

Capability and Capacity

In the first round of the research, some concerns were also raised about capability and capacity, first on DHB Boards and second within the 21 DHB organisations.

In the 2002 DHB Board member survey, 42% of respondents agreed or strongly agreed that they would like more training for their role as a Board member; 29% of respondents neither disagreed nor agreed; and 29% disagreed at some level (s).

CEOs noted some concerns about lack of technical skills, especially financial skills, and about a lack of depth of knowledge of the health sector amongst DHB Board members. CEOs were grateful for the presence of appointed members, while also appreciating the community knowledge and networks of elected members.

In one case study DHB, concerns were expressed about there being no national capacity to provide training, particularly for funding/planning and contracting roles. It was also suggested within one case study DHB that fragmentation of capability and capacity was a particular issue with respect to Māori, Pacific and public health expertise. This was reported to be especially noticeable compared with the critical mass of expertise that had formed under the HFA (Cumming, Goodhead et al. 2003, p. 100). Similarly, national stakeholders identified capacity and capability issues for DHBs, including concerns over DHBs' ability to manage devolved funds for the older disabled, contract management, and the capability to work in partnership with NGOs. As noted above, NGO informants suggested that with 21 DHBs, capacity and expertise had been split to an undesirable extent (Goodhead 2006), p. 56).

Shared Services Agencies (SSAs), Regional Mental Health Networks (RMHNS) and District Health Boards New Zealand (DHBNZ) were all ways in which expertise could be shared and collaboration promoted. The Interim Report discussed the roles that each of the SSAs was playing in the sector at that time, noting the importance of critical mass provided by SSAs for small DHBs, the specialisation of work, and the tensions over funding that can arise with such services (Cumming, Goodhead et al. 2003, pp. 101-102). In relation to RMHNS, a key issue raised in the Interim Report related to their different organisational structures and objectives, and levels of involvement with stakeholders. The research noted some confusion over the purpose

of the networks, with problems arising from a lack of direct involvement in DHB governance and accountability structures (Cumming, Goodhead et al. 2003, p. 104). Some uncertainty was also expressed over the role of DHBNZ in the early stages of the model, but its role was seen to have developed and consolidated over time, albeit with occasional concerns that it must not compromise individual DHB decision-making (Cumming, Goodhead et al. 2003, p. 105).

4.2.2 Devolution of Funding and Decision-Making

One of the key findings from the Interim Report was that informants indicated strong perceptions of reluctance to devolve funding and decision-making on the part of the Ministry of Health, that there were higher than desirable levels of central control, and that the Ministry had too great an involvement in operational matters. DHBs were also concerned about the limited amount of autonomy they felt they had in decision-making. Again, this finding was echoed in a number of parts of the research.

DHB Board members in 2002 had mixed views on this issue. In 2002, around a third (34%) of respondents felt that the Board had '*an adequate level of autonomy*'; a further 17% strongly agreed, bringing to 51% the percentage of Board members agreeing or strongly agreeing. Twenty-eight percent neither agreed nor disagreed, and just over 21% has some level of disagreement with the statement that the Board has an adequate level of autonomy (u). Māori respondents were more likely to agree that the Board had adequate autonomy.

Many of the CEOs communicated a strong perception of a reluctance to devolve on the part of the Ministry, with a view that the Ministry had too great an involvement in operational matters. One CEO pointed out that, while the model emphasises local decision-making, the failure (at that point) to fully devolve DSS and public health funding meant that this objective would not be reached.

There was also a feeling that the Ministry had control of the discretionary funds, again defeating the intention of local prioritisation. Some DHB interviewees were, however, ambivalent about further devolution of funding, noting their (then) limited capacity to manage contracts (Cumming, Goodhead et al. 2003, p.97).

Some of the comments made during interviews with case study informants similarly reflected concerns about devolution of both funding and decision-making, and hence about the autonomy of DHBs. In one Board it was noted that the amount of autonomy the sector has is debateable and the reality was that decisions were still centrally dictated. One case study informant noted the DHB was going to *'get the accountability delivering services, but we aren't going to get the responsibility for making the changes because so much as been prescribed'*.

Issues relating to devolution of funding and decision-making were relevant at a number of different levels in the system:

- Devolution of funding and hence of decision-making from the Ministry of Health to DHBs
- The role of strategies in planning and decision-making
- The role of the central government in funding decisions; in planning and decision-making, including through various accountability processes such as sign-off on DSPs and DAPs; and in performance management, including monitoring.

Each is considered in turn below.

4.2.2.1 Devolution of Funding

Funding for the Older Disabled

At the first round of interviews, funding for disability support services had not been devolved to the DHBs. Responsibility for funding remained with the Ministry of Health. Planning was, however, underway in relation to devolving the funding for, and hence decision-making for, DSS for older New Zealanders with disabilities, ie those aged 65 and over.

In one case study DHB, comments were made about the delays in devolving disability support funds, with the perception being that delays were due to the Ministry not trusting DHBs to spend the money on disability support services. One informant thought the Ministry was intending to devolve funding once the DHBs had demonstrated sufficient capability, and when the Ministry has confidence that national imperatives would be appropriately applied at a local level. A further viewpoint was that this had been wise of the Ministry because if all contracts had been devolved at the same time *'there would have been a bit of a shemozzle because there was too much to come to terms with at once'*. One provider informant did not mind the Ministry holding their contracts *'because our DHB is so dysfunctional'*.

One informant in this case study DHB identified operational problems caused by the devolution of personal health monies while the disability funds were retained in Wellington. For example, a terminal cancer patient with high dependency needs could be cared for under disability services and personal health services would later be invoiced. That flexibility in the system had been removed by the Ministry defining disability based on diagnosis rather than impaired functioning. This meant that some personal health clients with high needs were unable to be funded over the long term for home support or equipment. It was felt that once the funds for the older disabled were devolved, this issue would be resolved, although the same issues would continue to arise for those aged under 65. This barrier to accessing appropriate support was seen as worse for Māori who tend to become ill at a younger age. Obesity was another problem, which can generate high impairment of functioning but does not qualify as a disability support service.

In this same DHB, informants were confident that the DHB would be ready to take on the devolved funds. Good community networks and a willingness to *'really look at delivering'* were cited as positive factors. It was expected the proposed devolution would increase the effectiveness of the disability support services, as the DHB could more effectively monitor contracts locally. It was also expected there would be greater transparency for the community, who would then be able to see where the bulk of the money is going, and hence be more able to judge whether that fits with their awareness of the needs. One informant commented that: *'if we don't know better than the Ministry and if we don't deliver the community will come back at us'*. On the other hand, insufficient resources were seen as a constraint that could limit the DHB's ability to address everything in the DSS strategy and to meet the continuum of care criteria.

In another case study DHB, some interviewees, particularly from the DHB itself, supported further devolution of disability support services funding. One noted the mismatch between the government's legislative requirements for DHBs regarding people with disabilities and the lack of funding made available to DHBs. Others noted the advantages devolution would bring to developing integration with chronic care services provided by the DHB. Some could see the benefits in being able to develop closer linkages to DHB staff than they would with the Ministry.

However, in this case study DHB, the broad view among disability stakeholders and providers was that disability services should be regarded differently to mainstream health services. There was little support from non-DHB providers for further services to be devolved to DHBs. One interviewee clearly preferred responsibility for contracting to remain with the Disabilities Services Directorate in the Ministry because *'they know the services'*. Disability providers also expressed a preference for funding to remain with the Ministry. They were worried that devolution might lead to decreased levels of funding if decisions were made at the DHB level and feared that disability concerns would be swamped by mainstream health concerns and budgetary pressures. This risk was also acknowledged by DHB interviewees. According to one provider:

'I personally would be a little concerned because of the fact that this particular District Health Board allocates funds and the funding allocation is not necessarily in a manner that benefits everyone'.

In interviews with five national stakeholder NGO informants, three were in favour of devolution of the funds for the older disabled population and two were against.

On the positive side, informants hoped contracting directly with DHBs would be based on partnership. There were hopes that this would allow more flexibility to address the specifics of local issues, and to apply the policy intelligently in the local community. Some informants saw contracting with DHBs as an opportunity to try innovative new models of service delivery, with one particularly interested in how *iwi* and non-*iwi* services can work together. One informant commented that devolution of funding was the only way the Health of Older People Strategy could happen in a creative way.

One informant looked forward to building new relationships to reset the culture of the sector. This person expressed concern that some of the Ministry staff may be devolved with the policy. This was perceived as a negative because of the dictatorial relationships involved with contracting directly with the Ministry. It was also hoped that devolution may facilitate closer working relationships between different providers.

Informants also expressed concerns about devolution of funding for DSS. These included:

- the potential loss of national consistency and standard development;
- difficulties in maintaining funding for national coordination, training, monitoring and evaluation;
- the costs of contracting to 21 DHBs;
- that funds intended for disability services may be at risk of being siphoned off by the health model or the hospital driven system;
- concerns that the DHBs lacked the capacity to plan for and to manage the devolved responsibility, particularly as they have not been resourced to do the preparatory work;

- concerns arising from early feedback was that most DHBs are not handling the disability issues well;
- concerns that duplication of effort would occur as the DHBs did not understand the NGO sector well, whereas the prominence of the PHCS may mean more focus on primary care providers or the development of new services.

To mitigate risk, informants wanted good safeguards for devolved funds, and adequate resourcing for DHBs to plan the transitional work. NGOs reported that they were also taking a proactive stance to make themselves visible and to build network links. An umbrella organisation had facilitated the formation of an NGO reference group to monitor the sector and provide feedback to the Ministry.

Devolution of public health funding

At the time of the first round of interviews, public health funding also remained the responsibility of the Ministry of Health. We focused on this as a key issue within the main body of the research, and also undertook a separate study on this topic, which is reported below with findings from the second round of our research.

In one case study DHB, a number of informants commented on the anomaly of elected Boards charged with looking after population health and community accountability *‘but most of the shots are being called from the Centre’*. While accountability and contracting remains with the Ministry, *‘the DHB is developing a mind of its own as to what the public health needs are and what direction it should take and these two pathways are, not incongruent necessarily but they are different’*. One informant looked forward to the day when contracts could be drawn up just to do what the DHB wants. Informants suggested that earlier experiences around AHBs allocating public health funding elsewhere, and hence a lack of trust, were partially behind the decision not to devolve public health funding to DHBs. However, given that DHBs have a public health mandate with the expectation they meet population health targets, informants regarded it as *‘when’* rather than *‘if’* that the Ministry would devolve public health funds but there was no knowledge of the likely time frames involved. One informant challenged the structure of the reforms as reflecting philosophical inconsistency, reflecting the views of many of the informants: *‘the*

ultimate paradox is that, in the legislation, Boards are charged with protecting, promoting and improving the population health - great. And yet population health funding is still retained at the Ministry and directly from the health units...'. This informant was of the opinion that both disability and public health should be devolved as soon as possible.

In a second case study DHB, it was noted by many informants that the Ministry was not in a hurry to devolve services and acknowledged that much of the pressure not to devolve also came from some political parties. In this DHB, informants felt that DHB influence over national level public health decision-making was minimal even though attempts have been made to facilitate such input through DHBNZ. In this district, however, there were different views about whether public health services should be devolved to the local level. Board members and senior management would prefer devolution, so as to ensure some consistency in the allocation of responsibilities across the health sector. One senior manager clearly did not expect devolution to occur, while others suggested the government was not likely to devolve responsibilities for public health because of political pressure. The public health *'community of interest'* was also seen to generally prefer that the Ministry retains its current role. Reasons given for keeping this function at the national level included the need for national consistency in activities such as screening programmes and the need to retain a critical mass of public health expertise in a single organisational setting. As one interviewee remarked:

'...public health people know the risks of devolving small amounts of money which are no longer ringfenced and de-segregating a small workforce to 21 District Health Boards. I mean from my perspective I've seen what that's done to the Māori health workforce within the HFA that basically doesn't exist anymore'.

4.2.2.2 The Role of Government Strategies

One of the key issues for the research is the extent to which the health and disability sector works to implement key government strategies, such as the New Zealand Health Strategy, the New Zealand Disability Strategy, He Korowai Ōranga: The Māori Health Strategy, the Primary Health Care Strategy and the Pacific Health and Disability Action Plan. In the first round of our research, many informants made positive comments about key strategies and the need for such strategies, albeit with concerns over funding and implementation. There may, however, be a tension in having national strategies while also promoting local decision-making. In our research, central government requirements in relation to key strategies and government priorities have been seen to contribute to limits on the ability to DHBs to invest in their own priorities and to perhaps meet local needs. In this section, we consider these two issues in some depth: the extent to which DHBs embraced national strategies; and the extent to which national strategies and local priorities may or may not have come into conflict.

The first round of the research on HNA/prioritisation found that Government Strategies, particularly the NZHS, were a powerful force for all DHBs in their prioritisation processes. The HNA/prioritisation research found that key influences on DHB District Strategic Plans (DSPs) included legislation and Ministry guidelines. Government Strategies and the 13 priority population objectives strongly determined the direction of DSPs, which required sign off by the Ministry. DHBs received strong messages that the Government's priority objectives had to be reflected in DSPs, and it appears that this was an overwhelming influence on decision-making.

In the DHB Board member survey, we found that most Board members agreed that Government strategy plays an important part in DHB decision-making (82.6% agreed or strongly agreed) (b). DHB Board members were also asked about the importance of different key government strategies/objectives. Quality health services and Improved health status in the community were highly rated key objectives for DHBs, along with Reduced health inequalities and improved health status for Māori; Recognising the importance of the Treaty of Waitangi in decision-making; and Tackling high priority

public health issues. Less important were DHBs being environmentally responsible; Reduced health inequalities and improved health status for Pacific peoples; Increasing the confidence of the community in health services and Reduced waiting times for services. DHB Board members in some Boards scored some objectives as of higher importance than in other DHBs.

Similarly, the case study research has noted the important role that government strategies played in HNA/prioritisation processes. The NZHS was seen as setting an overall direction, but it was noted in that research that the health goals set out in the NZHS may not be as important in some DHBs as other identified local health needs. In the case study DHBs, it was expected that the HNA process would give the evidence-base to justify each DHB's strategic decision-making and prioritisation of services. As the case study report notes, all five case study DHBs used the NZHS as a '*sort of brief*', and DHB planning documents reflected national strategies.

For example, it was reported in one case study DHB, that the planning documents reflected government strategy overall. In this DHB, it was also reported that having national parameters already set is useful, provided that these do not conflict with local issues and needs. Informants also noted that there were '*good ideas coming out of the centre*' which were incorporated into the business plan. One concern, however, was where new policies and programmes were sought with no funding available to support them. It was also '*very frustrating*' if new directives occurred in the middle of the financial year, requiring unbudgeted expenditure. It was reported that this was occurring less often than previously.

In a second case study DHB, it was reported that the task of balancing local priorities and nationally defined health strategies was challenging, but no respondents reported that this was too difficult a tension to manage in the planning process. It was felt that the DHB's DSP, in particular, showed strong linkages between national and local priorities. It reflected the national-level emphasis of reducing health inequalities between groups, and the national priority given to primary health, mental health, cardiovascular disease and diabetes.

In a third case study DHB, it was recognised that the health goals set by the strategies may not be as relevant in some DHBs as other identified local health needs. It was therefore expected that the HNA process would give the evidence-base to justify DHBs' strategic decision-making and prioritisation of services to the Ministry.

In a fourth case study DHB, there was widespread support for the philosophical thrust of the strategies, but often mixed with scepticism and frustration that the money was not always available for implementation. One informant spoke of the New Zealand Health Strategy (NZHS) as:

'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'.

Others applauded the strategies as the answer to *'much of our health social problems'*, for the community consultation that had occurred around them, and the focus on health promotion and illness prevention. One Māori provider organisation commented the Government Strategies:

'were the closest we have had to our own philosophy, that is holistic approach, greater access, and focussing on population health rather than just face to face doctor-patient interaction'.

On the other hand, at least two informants thought there were far too many strategies:

'Phenomenal, phenomenal number of strategies coming out. Yeah an expectation originally that we were to turn our mind to all of them. Basically for us He Korowai Ōranga and the Primary Care, whānau ora is basically what we have based our strategic plan on'.

Particularly for a small DHB it was impossible to implement them all, and the lack of time and people resources would mean some would inevitably languish. One informant made a strong plea for focussing on just a few things rather than trying to do everything, and there should be no new strategies for at least a year: *'It's a time to just calm down and consolidate, do a good job of what we've got and then move on'.*

The PHCS also attracted comment. In one case study DHB, there was strong agreement with the philosophy of the PHCS:

‘We totally agree with Government that we are not going to get any of those other things like financial performance, community involvement, reducing inequalities and improving health status unless you get something done in primary care development’.

Informants expressed high expectations of the PHCS to deliver significantly better health outcomes, thus reducing the need for secondary care; making primary care more accessible to a larger group of people; offering primary care in a number of different ways that haven’t been done before and in different venues; and allowing GPs to work with other health providers *‘to come up with sensible solutions with that level of cooperation’.*

In this same case study DHB, however, the PHCS has brought \$2 million extra funding into the district, but as one informant explained, the DHB is only a conduit for this money, as it goes from the Ministry to the DHB, straight on to the providers based on their enrolled population. Although the DHB has to agree with the providers about what they are going to do with the money, in practice the incentives are structured for the DHB always to agree. If the DHB did not agree the money would stay at the Ministry. This informant speculated what the DHB may choose to purchase if it was a new funding initiative. While not questioning the value of the PHOs, other primary care needs exist which are not covered in the PHO funding. Midwives, dentistry, Māori health providers, community mental health were mentioned as falling into that category.

4.2.2.3 The Role of Central Government in Planning and Funding Decisions

Another potential impact on DHB decision-making relates to the role of central government in planning and funding decisions. DHBs, along with other stakeholders, have concerns about the degree of central decision-making within the system on the ability of DHBs to make decisions appropriate for their local districts.

This research has reported examples of the role of central government in planning and funding decisions from a number of sources.

In a separate piece of research on health needs assessment and prioritisation, the researchers noted a number of reported barriers to effective decision-making *at a local level*. Health needs assessments had relatively little influence on the direction of planning and purchasing. The main reason for this was their lack of service planning and purchasing specificity. Health needs assessments conducted in DHBs that focused on planning at the service level and in relation to population subgroups using a ‘mixed-scanning’ approach and ‘service planning groups’ (i.e. assessing needs and priorities within sub-groups of services) had a greater impact on planning and purchasing than those that did not. Although DHBs developed prioritisation frameworks, they found it difficult to use them in practice. In large part, they saw this as due to the level of control exercised by central government over their actions. As a result, DHBs found that they had little flexibility to respond to the needs and priorities of their communities (Coster, Mays et al. 2006). Reported barriers included: unclear boundaries of responsibilities between the Ministry and the DHBs; inconsistent messages and requirements coming from the Ministry, such as the requirement to carry out prioritisation when health priorities had already been set; and political interference (Coster 2004).

The case study research similarly indicated the important role of central government in decision-making. Case study informants indicated that prioritisation and planning were largely driven by Ministry requirements and directives. It was felt that there was not much opportunity to demonstrate local leadership, partly because of the priority objectives of not only national health strategies, but also because of service coverage specifications and deficit reduction requirements. Furthermore, DHBs received service level requirements from the Ministry, setting out the Ministry’s expectations regarding levels of health service provision.

At times, the role of central government was seen to be more direct. We noted in the Interim Report that some DHBs endeavoured to manage deficits downwards by reducing access to services and reported that they were promptly told this could not be done (Cumming, Goodhead et al. 2003, p.49).

A number of other examples of the role of central government were provided in the case study research:

- In one Board, the unwillingness of the Minister to sign off the annual plan caused tension, when the Board considered their plan both reasonable and feasible.
- There was a comment in one Board that central government could still dictate what has to be done and it has to be paid for, eg fertility and surgical services.
- In another Board it was commented that the Ministry had intervened in contracting decisions. It was suggested that this set a precedent for the future and could be challenging if the DHB has to find the money itself.
- Ringfencing of funding was perceived in one Board as a major constraint, and although it may be a pragmatic approach for a period of time, it is seen as being used too often and should not be there '*in perpetuity*', for example in mental health (Cumming, Goodhead et al. 2003, pp. 98-99).

It was noted in one Board that it was not clear where the locus of decision-making lies. DHBs are charged with needs assessment and prioritisation and yet their funding decisions are constrained by national frameworks and (on occasions) interference in local decisions by the centre. It also appeared to some informants that the Ministry has the discretionary health dollar (eg, for the meningococcal programme), and yet according to the model, it is the DHBs who should be making resource decisions (Cumming, Goodhead et al. 2003, p. 98).

In one case study DHB, comments were made particularly about the role of central government documents and processes; for example,

- the operational policy framework (the quasi-regulatory framework within which DHBs operate)
- the service coverage schedule
- accountability indicators
- DAP Guidelines.

It was noted that the relevant Ministry documents tended to be very large, and DHB staff worked with counterparts at other DHBs under the aegis of DHBNZ, to share out the work of analysing the documents. The service coverage document, although very broad, was specific in parts and its general tone was '*to maintain and increase services, so in effect it act[ed]... almost like a prioritisation document in itself*', and

this was seen to be in conflict with the DHB's own prioritisation process. The service coverage document, according to one informant, was increasingly more detailed, with service specifications and detailed expectations. When services were specified to a very detailed level, the effect was that prioritisation decisions were already made, and there was little point to the whole DHB infrastructure, community involvement and strategic planning. In the mental health area, the mental health blueprint, in the view of an informant, was '*unduly prescriptive*' about resource allocation and service provision. Another informant thought that this and ring-fencing mental health funding could be a barrier to a more holistic service.

In another DHB, it was felt that the Ministry reporting requirements were prescribed and include quarterly reports on the accountability indicators, a monthly financial report against a reporting template and an Annual Report. One informant said there had been consultation processes with the Ministry at an earlier stage but they did not feel they had any influence over the reporting requirements, which were perceived to be driven by Government's priorities. Some were critical of the monitoring by the Ministry as indicated by comments such as that it included some '*unnecessary monitoring*'; they never knew what happened to the information; and that they sometimes '*report the same stuff over and over*'. Being a small DHB meant the reporting was a relatively greater strain on limited resources and capacity. Also, given the difference between DHBs, not all questions were meaningful to all DHBs and the DHB did not necessarily have the information that fits the question.

However other informants accepted the reporting as '*necessary*', commenting that '*some of the measures are quite helpful for us as well*' and that this reporting has been used as a starting point, structure, and process for the Board's own monitoring. Others saw gains from the greater transparency in the current regime than in earlier years.

In one case study Board, the role of DHBs in prioritisation was considered in some depth. DHB analysts produced a lengthy report on the role of DHBs in prioritisation processes. The funding team of one DHB experimented with a principles-based scoring system and the priority-ranking of all contracts in order to advise the Board on options for managing a projected \$2m deficit in the funding arm. The process gave some useful indication about where dis-investment might occur (which is critical,

given the need to reduce deficits). However, reducing the level of service provision proved politically unacceptable and the Board was directed not to reduce particular services. The general conclusion was that, given (a) that DHBs have limited resources, (b) many prioritisation decisions are applicable to all DHBs, and (c) many prioritisation decisions are made at the national level (including decisions which relate only to local services), any further development of a prioritisation process should be undertaken at the national level (Cumming, Goodhead et al. 2003, p.207). This DHB, along with others, moved to a position on prioritisation that emphasised within-service rather than between-service priority-setting. A background paper prepared by management recommended that:

‘explicit prioritisation processes at a programme or services level are too difficult for an individual DHB, particularly in an environment of disinvestment and reallocation’, and that

‘the constraints of the current operating environment make disinvestment decisions untenable unless there is political and national support’.

The paper recommended that DHB focus on *‘lower levels of prioritisation’*, defined as the clinician/consumer interface rather than the programme level, implementing national prioritisation decisions (e.g. booking systems), and improving technical and system efficiency. The paper also argued that between-service prioritisation should be handled at the national or regional level. An important part of this argument was that the DHB did not have the resources and capacity to engage in the data gathering and interpretation of data necessary for robust priority-setting between services.

4.2.3 Capacity and Capability

In an environment where funding and decision-making are devolved to lower levels of government, a key issue is whether local agencies have the capacity and capability to undertake the key roles expected of them. This has been a key theme for this research.

At the DHB Board level, the DHB Board members gave mixed views about whether they were adequately informed about relevant issues prior to election or appointment.

Forty-five percent agreed or strongly agreed that they felt adequately informed prior to election or appointment, and 30% disagreed or strongly disagreed.

CEOs at that time reported that elected members tended to lack technical skills, particularly financial skills and depth of knowledge of the health sector. The community knowledge and networks of elected members were highly valued by CEOs, but overall they were grateful for the presence of appointed members. Similar views were expressed in the case study research, with the election process potentially leaving DHB Boards with a poor mix of skills and gaps in expertise, variable abilities amongst the DHB Board members, and imbalances in sector interests (Barnett and Clayden 2007).

Many informants throughout the research have commented on issues relating to capacity and capability at the organisational level, particularly relating to DHBs as organisations. In the key informant interviews in the first round of data collection, two key informants were concerned that the technical capability of the HFA would be lost with devolution. Officials we interviewed noted that guidelines were given to DHBs during implementation, indicating that the government intended shared services agencies to be established, in order to promote efficiency, to protect the capacity of the HFA in technical areas (such as HNAs), and to make sure small DHBs that would otherwise not be able to obtain some skills, still had access to capacity for technical tasks.

In the case study DHBs, a number of issues were raised relating to capacity and capability. In one DHB it was noted that there is no national capability to provide training. At that time, many DHB personnel were still trying to come up to speed in terms of handling contracts, understanding what the national frameworks mean and translating these into contractual agreements. In the same DHB it was also commented that the NZHPDA model had fragmented the critical mass of expertise that had been formed under the HFA (such as Māori, Pacific and public health expertise). In another DHB it was noted that new skills were required in a short time frame, particularly in the funding positions as this was a completely new area. Up-skilling in contract management took time, and in part led to the rolling over of contracts during a capacity building period. Another area where concerns were raised

was in relation to hospital performance issues, where it was commented that the DHB (through a Hospital Advisory Committee) was not able to fulfil its role completely primarily because of inadequate information, and a long-standing lack of robust analysis and synthesis. This was seen to have been a longstanding issue and relates particularly to the lack of robust analysis and synthesis arising from lack of analytical capacity and capacity (as well as occasional ‘stone walling’ by management). A general comment was made that there was ‘*a lack of numeracy and understanding on the operational side of the business*’.

Some NGO providers interviewed as part of the case study research also expressed concern in the first round of data collection that there is no primary care expertise within the DHBs at the senior management level.

One informant in a professional organisation 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’.

4.2.4 Collaboration Between DHBs

Collaboration is a key issue for the reformed model, particularly given concerns over the number of DHBs and over capacity and capability issues.

As we noted earlier, officials we interviewed as part of key informant interviews suggested that guidelines were given to DHBs during implementation, indicating that the government intended shared services agencies to be established, in order to promote efficiency, to protect the capacity of the HFA in technical areas (such as HNAs), and to make sure that small DHBs, which may not otherwise be able to obtain some skills, still had access to capacity for technical tasks. Key informants also noted

there are a lot of ways in which DHBs can share activity, for example, in relation to shared financial systems, human resource systems, HNAs or contract management. It was noted that early on in the reform process, the Ministry of Health asked DHBs how they would establish shared services agencies. The regional model, through four SSAs, then grew out of the then existing HFA locality offices, giving the SSAs institutional memory (Cumming, Goodhead et al. 2003).

One key informant suggested the SSAs would only be used during a transition period, as:

'a way of boards keeping the HFA staff doing some stuff. Increasingly boards are going to take over the role themselves and I think this shared service agency stuff will fall by the wayside' (KII 6) (Cumming, Goodhead et al. 2003).

In the case study research, a number of issues were identified as relevant to collaboration between DHBs. It was noted in one case study DHB that the large urban areas present some special issues and required regular inter-DHB consultation. At the time of the first round of data collection, neighbouring urban and regional DHBs were working through the issues, and relationships were developing. It was reported from this DHB that overall the development of the SSA seemed to be going well at that point, though its resources are limited.

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

One way in which DHBs work together is through the establishment of joint contracts, with a 'lead' DHB responsible for contracts. Some informants expressed concern about this approach. For example, in one DHB it was noted that while the lead DHB clearly holds the full contractual risk, it often has little control over the use of services by the populations of other DHBs. In one case, a lead DHB felt that because it is fully accountable under the contract, any final decisions about changes to these contracts must rest with the lead DHB. In contrast, the other DHBs considered

that, because any changes to these contracts will impact on the populations of all of the districts covered by the contract, decisions should be made jointly. Moreover, any savings should be shared by all three DHBs.

The Shared Service Agencies, Regional Mental Health Networks and DHBNZ are specific ways of co-ordinating efforts. Findings from the first round of the research in relation to these agencies are described in fuller detail below.

4.2.4.1 Shared Service Agencies

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

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

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

Each has developed specialist areas of work for which they are recognised, including a research and analysis focus (TAS), service and relationship management (NDSA), change management (SISSAL), and auditing (Healthshare). They also have different

governance arrangements. There has been some tension between individual DHBs and regional interests. SSAs can act as mediator in such situations. Alternatively, SSAs can represent groups of DHBs in national forums.

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

In the first round of our research, we noted that there are some tensions between DHBs over the funding of SSAs. Funds were initially committed to SSAs for only short periods. However, the SSAs do not regard themselves as short term agencies, and expect that they will continue to evolve with the ongoing development of the DHBs, for example the development of Primary Health Organisations and population-based funding are likely areas of new work.

Case study informants indicated that the development of shared services agencies was seen as going well although resources were seen to be very limited.

4.2.4.2 Regional Mental Health Networks

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

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

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

According to informants, the mental health sector struggles with problems of acute workforce shortages, poor access to regional services by some patients, duplication of services across some DHBs and gaps in others, low involvement of key stakeholders, difficulties in establishing quality monitoring frameworks, and poor communication between services. The research also identified significant actual and potential problems facing the Networks. There are low levels of technical planning expertise, conflict between individual DHBs based on their assessed needs and regional priorities defined by deviation from the *Blueprint*, existing funding inequities within regions, problems around cross-boundary charging and inequitable contributions to regional services, and the potential for power struggles between DHBs and their regional Network.

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

4.2.4.3 District Health Boards New Zealand

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

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

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

4.2.5 Adaptation of the Role of the Ministry of Health

As part of the research, the researchers were asked to look at the adaptation of the Ministry of Health as one of the key themes of the research. Findings related to this theme are included here, given the link between issues relating to the role of the Ministry of Health and to devolution.

In the 2002 Board member survey, 36% of respondents felt strongly that the Board needs more support from the Ministry and the government; a further 23% agreed, such that 59% agreed or strongly agreed with this statement. Nineteen percent disagreed or strongly disagreed (p). There were statistically significant differences across DHBs, with one smaller main centre and two provincial/rural DHBs ranking as the highest scoring DHBs. In the same survey, 36% of respondents strongly agreed they feel there are times when Ministry and government interfere inappropriately in the work of the DHB; a further 27% agreed. Altogether 64% of respondents agreed at some level with this statement (one person gave a score of 5.5). Twenty-one percent disagreed at some level while 15% neither disagreed nor agreed (g).

In the first round of interviews most CEOs reported that their relationship with the Ministry was either good or improving. They acknowledged the difficulties faced by the Ministry in implementing the new reforms in a relative short time period, and there was high regard for senior Ministry officials, some of whom had been very supportive of CEOs individually. There was, however, a strong perception of reluctance on the part of the Ministry to devolve (*'the empire strikes back'*) and too great an involvement in operational matters. Several CEOs reported on excellent relationships with account managers, but saw a need for improved co-ordination and reduction in 'single issue desks'. There was an expectation that over time the Ministry and Boards will develop a more appropriate relationship based on their statutory roles and responsibilities.

Informants in the case study districts offered both positive and negative comments in relation to the role of the Ministry of Health. In terms of devolution, overall, the Ministry was seen as too bureaucratic and prescriptive; focusing too much on operational issues and *'micro-managing'*. This was seen to stifle flexibility and

innovation at a local level. In one Board, it was noted that the amount of autonomy the sector has is debateable and the reality was that things were still centrally dictated. Another case study informant noted the DHB was going to '*get the accountability delivering services, but we aren't going to get the responsibility for making the changes because so much as been prescribed*'. A number of examples were given earlier, leading to DHB informants having concerns around autonomy.

In one case study Board, the comment was made that central government priorities are not always the same as local priorities and can create tensions. Local innovations can sometimes be at odds with the need for national consistency. This same Board commented that national standards should be set before devolution. It was commented that the Ministry can cut across and not fully understand the role of the DHB and the planning of services (Cumming, Goodhead et al. 2003, p. 107).

There was also a perception that the Ministry has a large resource that has changed little; that it has not shifted from funding back to policy and not upgraded its skills to reflect this change (for example, one case study informant commented on monitoring, which they saw as a huge skill set, not focused on areas of need); and that it needs to rearrange itself but is not there yet. In one Board the feeling was expressed that the Ministry had not downsized and taking on new role, causing tension and conflict. In another Board, the comment was made that the Ministry should downsize and focus on strategic direction.

In one Board it was commented that DHBs look to the Ministry for strong leadership, a co-ordinated approach, strong policy development but not interference in implementation. One comment was made that Ministry staff need experience outside the policy field; it is suggested that it would be helpful for Ministry policy staff to have experience working at the implementation and DHB level.

In one Board it was suggested that workforce planning and development, particularly for Māori, needs national rather than local attention. In another, the comment was made that DHBs are ‘*all working in a bit of a vacuum*’, and there is a need articulated to advertise successes around the country to understand what works, particularly in the area of integration (Cumming, Goodhead et al. 2003, pp. 217-220).

In one case study DHB, many informants stressed that it was the design of the system that they saw as most problematic. One noted the ‘*sheer plethora of activity*’, and another expressed concern about the amount of DHB resources required for senior staff to be present at meetings in Wellington. According to one:

‘The relationship with the Ministry, I think everyone’s trying to make it work. But it’s such a basic infrastructure problem that you’ve got a lot of people in the Ministry working still in their little pet silos, with no accountability. And it does come back to organisational design and structural design of the sector. You’ve got to get your accountabilities right, so if you’ve got 1000 people busy they will be busy. But if they have no accountability and the accountability rests with the DHBs then you’ve got basically ... it’s just set up to have tensions. So it comes back, the reason it works is by the individuals in the system and their relationships and the good will they invest into it. Not because the system is set up to make it work. It’s very inefficient.’

The overriding concern of DHB personnel was the lack of clear lines of demarcation between the DHBs and the Ministry. This appeared to be the main faultline of the tension between national policy and consistency and local responsiveness. Perhaps predictably, most DHB respondents thought that responsibility for policy implementation should be vested predominantly with DHBs, and that the role of the Ministry be limited to policy advice. From the perspective of the DHB, the biggest frustration they felt was that of being accountable for policy implementation without having control over it.

In one DHB, in relation to strategic planning processes linked to accountability requirements (eg, DSPs, DAPs, etc), one informant noted the Ministry timeframes to be unduly restrictive. ‘*It’s a very tight timeframe, we need to include financials and everything else in it, need to do it ahead of time which makes it difficult to project*’.

In this same case study DHB, the control by the Ministry over the PHCS was also seen as problematic: *'The current tendency is for the Ministry to hold onto what is happening with the PHCS and I can understand that, because they're obviously nervous about what DHBs may or may not do'*, recognising they would have been charged by the Minister to make sure the \$50 million available that year is released in a controlled manner to actually make a difference within three years. However, this informant felt that *'if it's going to be successful then there needs to be a lot more letting go, letting the money come out to DHBs and then the DHBs making decisions about what to do about primary care with their local communities'*.

In the same DHB, the Ministry was also seen as punitive rather than supportive in relation to this pressure to achieve the desired result of eliminating the deficit.

One informant from this DHB also noted that the DHB did use the contract template developed by the Ministry, and that it was helpful. This informant thought it could be improved further if it was shortened, and that it was too rigid. *'[They] have contracts set in stone almost, and any provider specific terms and conditions can only negotiate if the terms don't go against anything in the main agreement.'* In the view of this informant this unnecessarily hampered the process so that for the 5% it didn't work with, the template is put aside.

4.3 Findings – Later Expectations and Experiences

4.3.1 *Expectations*

In the second round of interviews, informants across all streams of the research were asked about their thoughts on devolution of decision-making and autonomy, picking up on this key theme identified in the first round of the research and in the Interim Report.

The discussions on devolution took place in a context where, in the second round of interviews held in 2004, key informant interviews were more likely than in the first round of interviews to identify community involvement in health as crucial to improving the health of communities and to reducing inequalities. The potential health gains from engagement of communities with both DHBs and Primary Health Organisations (PHOs) were mentioned frequently. Key informants noted that the reforms were more than just about having members from the community on DHB Boards or statutory committees; they noted the importance of community support to key policy goals, such as reductions in smoking or increases in exercise. One key informant noted that:

‘...from a public health perspective...it’s not just about democracy...community engagement is actually about changing the way community works in, on public health matters. So if you look at the Ottawa charter it’s about healthy public policy and community engagement. If you’re going to get people to stop smoking you need families and communities and support’ (KII 8 R2).

This key informant went on to suggest that the settings we now have in the health sector are for the first time conducive to being able to address the significant health issues relating to, for example, an ageing population, diabetes and depression. Thus;

‘...having the local responsibility for the health or the population I think is tremendously important. It enables other government agencies to work locally and then having the PHOs as outreach tools and with the investment in primary healthcare we’re set for being able to make a significant difference...’ (KII 8 R2).

The need for an inter-sectoral focus – eg, DHBs working with local governments – was also raised in this context (Cumming 2006, pp.14-15). One key informant noted the importance of local networks to work on health-related service delivery. This included having networks of health providers but also health providers working with other local agencies – such as education, police, youth aid – etc, to promote health. Another noted how important health services are to local economies – noting that in some communities

‘industry wants a good health service to recruit and the hospital needs to have a good industry for economic reasons...’, and that

‘in the smaller places the hospitals are the biggest employers, they really are part of the community’ (KII 6, R2) (Cumming 2006, pp. 14-15).

When it came to discussing devolution in the second round of key informant interviews, it was noted by Ministers and officials that they did not always know what was meant when it was suggested that DHBs did not have sufficient autonomy, but they stressed that DHBs do have the autonomy to make decisions, for example around health strategies and health goals. They agreed that DHBs do not have the autonomy to decide not to provide abortion services, for example, or to push a particular barrow. *‘But they have all the autonomy in the world to develop programmes and approaches to diabetes, to cardiovascular disease...’* (KII 11, R2). In this vein, it was noted that the NZHS is a national strategy, developed in consultation with many people in the sector.

Officials pointed to a key factor that leads to a fairly centralised model: it is central government that pays for health, and which is always going to be accountable for that funding. This meant that organisations working in the sector needed to realise how this may lead to constrained decision making at a local level.

Key informants noted how important it is that policy settings not lead to inconsistency as *'New Zealanders believe in fairness ...we all want access on the same terms...'* (KII 9, R2). This informant went on to say that although DHBs may want greater autonomy, at the moment the policy is to try to get national consistency. This was discussed both in terms of service coverage, and also in terms of the quality or standard of service delivered.

One key informant noted that the DHBs do not:

'really like having direction or having input from the Minister, but that's too bad...if anything goes wrong they want [the Minister] to be responsible. And also sometimes they don't see the bigger picture and I'll give you an example. [The Minister] wants the DHBs to work together with Pharmac for Pharmac to purchase hospital pharmaceuticals. Pharmac's brilliant at negotiating prices. Each purchasing agent of each DHB are busy out there trying to buy their hospital drugs and, and at a much higher cost than they need to. [The Minister] had to say to the CEOs you've got to work together on this. They have, they've had a brilliant result. But if you let them all to their own devices they weren't going to. So every now and then [the Minister's] got a role to play as well' (KII 11, R2)

Other informants also noted the tension between local and central decision-making. One key informant suggested that *'as more DHBs get into the black, the Government is likely to be much more relaxed about local decision-making'* (KII 8, R2). This informant felt that already there is significant discretion – and felt a need to make sure the Ministry of Health knows where the added expenditure is going. This informant suggested that when DHBs are in deficit, they feel they have few *'degrees of freedom because we certainly don't want them slashing and burning services – we want them making measured decisions'* (KII 8, R2). This informant also stressed the importance of prioritisation processes, for circumstances where new money is available and where disinvestment decisions need to be made. They also felt there is *'quite a degree of maturity which is tremendously helpful because that then gives government confidence about more devolution'* (KII 8, R2).

One senior official noted that key to the model is *'the balance of being community responsive and working with local communities and working with other sectors and getting that ground up community innovation stuff with the national priorities and drivers and managing that tension...'* (KII 3, R2).

Some officials commented that perhaps in five years, there may be a different model. For example, the Ministry of Health at the time held primary care policy and funding responsibilities, and the key task was for the Ministry of Health – accountable for implementation of the model – to work with DHBs in partnership to implement the PHCS. The longer term aim should be to further devolve funding and to put these into the population-based funding formula. Some officials felt that public health funding should also be devolved to DHBs in order to do their job properly.

4.3.2 *A Local Focus*

4.3.2.1 Support for a Local Model

The support for the NZPHDA model found in the first round of data collection was also clear in the second round of data collection.

DHB Chairs were also extremely positive about the DHBs, although as political appointees this support may well be expected. The local focus was strongly endorsed: *'a sense of community ownership again'*, *'a local focus for all health services'*, with *'increased public confidence'* in the system overall. The strategic, population-based approach to health was also supported by DHB Board Chairs.

A majority of Chairs endorsed the strategic, population-based approach to health. This required the DHB to plan 'across the board' for all services, but with some inevitable consequences. First, is a need to redefine the role of the hospital. Several Chairs commented that a significant change in thinking has been required to ensure that proper attention was given to primary care and public health. A typical comment was: *'there has been a subtle change in thinking, to think in 'whole-health' terms, not just hospitals'*. Some Chairs also acknowledged that there was still work to be done in integrating the system, with one specifically noting that 'hospital culture is still a barrier'. Second, is the need to recognise that it will take time for the benefits of the new arrangement to be evident in terms of improved health. No Chairs expected benefits to flow quickly: *'success will be over the long haul'*; *'it will take 15 years'*.

There was little change in the second round of interviews in the assessment by CEOs of strengths and weaknesses of the system. The view that the strengths lay in the single funding pool and the ability to make local decisions was maintained.

In the case study research, the NZPHDA model was approved of for a number of reasons, including because it has: a strong focus on promoting health; more openness and transparency; greater integration between the hospital and the community and between services generally; increased flexibility and scope for innovation; a focus on promoting collaboration; strong national guidelines to counter any tendency towards fragmentation; and because it allows local purchasing, approved of because '*local areas know local needs*'. The key goals of the reforms were supported – striving for population health, reducing disparities in health, local accountability, increased participation and ownership of decisions by the community, and greater responsiveness to assessed needs locally. Some Māori informants commended the holistic approach and the reference to the Treaty in the NZPHDA was seen as a strength by some Māori. Case study informants saw community involvement in strategic decision-making as increasing understanding of key issues and enhancing ownership of selected solutions, and it was seen to have the potential to promote health.

In one DHB, the DHB model was seen as potentially a more effective funding agency than previous models, but this status has not yet been fully achieved. In another case study DHB, an informant commented that local people:

'are always going to have greater knowledge of what the local needs are and the local people are the ones that are going to have to carry out the projects, [they] need to have an input...a degree of ownership...for them to be able to actually make it work. It's never going to work when someone in Wellington says this is your priority when the local people don't believe it is a priority, well they're not going to make that work are they?'

In this same DHB, one informant noted that '*there's more kanohi ki te kanohi now – because it is local more people participate*'. Community engagement in one DHB was also now seem as more meaningful, with a directness of accountability between decision-making and community feedback. In another case study DHB, key strengths were, *inter alia*, the potential to enhance local input and decision-making and greater

accessibility of DHB staff, as well as the opportunity for inter-sectoral decision-making.

Second round interviews with national stakeholders similarly continued to indicate support for a local model. NGOs approved of community input, transparency and an emphasis on co-operation, local relationships, the building of local knowledge, greater flexibility of services, more innovation, opportunities to develop a shared vision and more direct accountability (Goodhead 2006, pp. 56-58). Several informants considered local approaches as more conducive to innovation, particularly amongst smaller DHBs, with one informant attributing this to the closeness of relationships between providers and smaller DHBs. It was also observed by one informant that accountability was more direct with local approaches to contracting, with DHBs looking for more robust service delivery.

In the second round of data collection, members of the research team also interviewed a number of informants from professional organisations. Those interviewed also generally approved of the NZPHDA model, with a number feeling the model was more congruent with their own philosophies. The system was viewed as encouraging more collaboration than competition, with increased opportunity for consultation also, and an emphasis on ‘doing good for the community’ (Goodhead 2006), p. 61}. Local input was generally viewed positively also by professional organisations: *‘It certainly seems to me from where I sit that local input is important to the model and it has made a difference’*. A number of informants suggested, however, that the expected benefits have been slow to materialise as previous cultures have persisted. A collaborative environment was seen to have facilitated tripartite employment relationships and agreements, and DHBNZ was seen as useful in supporting regional and national collaboration. The increased opportunity for consultation and a shift to focusing on doing well for the community were seen as positive and unifying features of the model. Those interviewed considered that DHBs had adapted well to the new environment.

4.3.2.2 Weaknesses of a Local Model

As an overview of the model, several DHB Chairs rejected beliefs that there was an implication that the reforms would not involve major change, when the reality was that an enormous investment of time had been required throughout DHBs to ensure that change occurred properly. The costs of change had not been acknowledged or widely understood. One suggested that additional funding for change would have made the transition to the new system more manageable. The deficit situation for some DHBs was also reported as making the implementation of DHBs particularly difficult. On-going tension regarding finances and the need to restrain hospital budgets had contributed to *'draining away all the imagination and innovation'*. DHB Chairs acknowledged some concerns around DHB Boards not being sufficiently strategic, and not thinking about the district as a whole rather than just the geographical area DHB Board members came from. DHB Chairs reported considerable effort in working with Board members on these issues.

For CEOs, the weaknesses identified in the first round persisted, but there were the additional insights as to how those might be handled. Apart from the removal of required statutory committees and a mild hankering for fully appointed boards, there was a strong view that structural change was not required and would be detrimental (*'I just hope the buggers leave us alone'*). In general the perceived weaknesses were being actively managed through collaboration across DHBs, through DHBNZ, through working towards better relationships with the Ministry and the access to devolved disability funds.

Specific comments were made in relation to a number of weaknesses; these included comments on accountability, the number of DHBs and a higher than desirable degree of central control. Issues relating to accountability are included in this section; issues relating to the number of DHBs and higher than desirable degrees of central control are discussed separately.

Accountability

Accountability was again an issue which the research explored in the second round of data collection. The DHB Board member survey asked again in 2004 if the Board sees its primary accountability to the government, not the local community. As with the 2002 results, there were mixed views on this. In 2004 53% gave some level of agreement; 30% of respondents neither agreed nor disagreed, while 17% disagreed (c). In 2004, there was a slightly higher percent agreeing than in 2002, with fewer also neither agreeing nor disagreeing. In response to a question about whether elected members 'feel able to handle the dual accountability to my community and the Minister of Health', a total of 72% agreed at some level; twelve percent neither disagreed nor agreed; and 16% disagreed at some level they were able to handle dual accountability (k). There were differences in responses between the two surveys, with the percentage reporting feeling able to handle the dual accountability to their community and to the Minister of Health, increasing over time. As in 2002, appointed members were asked whether they 'feel principally accountable to the Minister of Health'. Sixty-five percent agreed or strongly agreed; 7% neither disagreed nor agreed and 28% strongly disagreed or disagreed (l). Finally, in response to a question asking Māori DHB Board members whether 'my accountability to whānau/hapū/iwi is a source of personal tension for me', 65% strongly disagreed or disagreed; 30% agreed or strongly agreed (m).

DHB CEOs did not report major concerns over the understanding of accountability issues in the second round of interviews, although they noted that some issues were still present, for example:

'On occasion you will have members that forget that they are representative of all residents of the DHB and tend to look to their own district or area. So we do have those issues coming into play at times'. (CEO 1)

While CEOs reported difficulties for individual members from time to time, in general this was dealt with via the Chair. Some CEOs reported that as the 2004 elections approached they noted 'electioneering' behaviour from some elected members and expected some destabilisation of the board as a result of the elections.

In the second round of interviews, some informants from professional organisations also noted a number of weaknesses with the NZPHDA model. In some cases, things were not seen to have changed much on the ground yet. One concern was that DHBNZ is not a statutory body, with one informant concerned that DHBNZ was having to develop policy at the implementation level given a vacuum existed in relation to national implementation policy. Some concerns were also raised about the process of consultation, with some suggesting this to be ‘lip service’ at times, and comments made about the sheer quantity of documents organisations are asked to comment on (Goodhead 2006, pp. 60-62).

The role of the community

Although it was generally acknowledged that involving communities in decision-making at a local level was an important aspect of the NZPHDA model, some participants briefly noted several issues relating to the role of the community. One participant wondered whether the community is able to articulate its real needs:

‘The public tend to construct a lot of their requests around the need for more general practitioners, closer access to hospitals. They tend not to talk about the broader concepts of health around support with parenting, nutrition, safety, breastfeeding ... I don't think that's because the community doesn't want this, but they tend not to articulate those things in the public debates because they think public debates about health service delivery are about GPs and hospitals. So that's what they talk about’.

Another respondent noted difficulties around defining ‘the community’ and around ensuring meaningful community participation in decision-making within a very complex sector:

‘Community representation is an ideal; there should always be the capacity for community input because that's important. [However] it's hard to define the community and it's hard to find some people within the community who are willing to provide that input for anything other than personal barrows that they want to push’.

Another participant noted that time was also needed for effective community relationships to develop. This would mean that the NZPHDA model would take some time to bed in:

‘Community relationships, like any relationship, should be allowed to develop at its own pace and when you force it, it either gets done in a way that pays lip-service to it, or it forces bedfellows together who actually don’t fit together in the form that they are at the present’.

4.3.3 *Devolution of Funding and Decision-Making*

Again in the second round of data collection, issues around local and central decision-making were a concern of key stakeholders working in the sector. General comments on this issue on included here, followed by more specific examples relating to devolution of funding; the role of government strategies; and the role of central government in planning and funding decisions follow.

In the 2004 Board survey, the wording of the question relating to autonomy was changed from ‘The Board has an adequate level of autonomy’ to ‘The Board has sufficient autonomy to decide how to spend its resources’ to improve clarity in the question. In 2004, twenty percent agreed with this statement and a further 12% strongly agreed; thirty-two percent therefore gave some level of agreement that the Board has an adequate level of autonomy. Twenty-seven percent neither agreed nor disagreed, while twenty percent disagreed and twenty-one percent strongly disagreed (u). Females were more likely to agree than males. In 2004, there were statistically significant differences across DHBs, with some smaller provincial/rural DHBs ranking as the highest scoring DHBs (more likely to agree). Assuming the question was responded to in the same way in 2002 as 2004, there were also differences across time, with a *decrease* in the percentage of respondents with some level of agreement that the DHB has an adequate level and an increase in the percentage disagreeing or strongly disagreeing.

As noted earlier, the DHB Board member survey also included a question on personal experiences relating to the NZPHDA model, and asked respondents to rate whether they feel there are times when Ministry and government interfere inappropriately in the work of the DHB. In 2004, 45% of respondents strongly agreed with the statement

that they feel there are times when Ministry and Government interfere inappropriately in the work of the DHB and a further 26% agreed. In total the proportion of respondents who agreed at some level with the statement was 72%. Very few strongly disagreed or disagreed with the statement (9%) and 19% of respondents neither disagreed nor agreed (g). There were differences in responses between the two surveys, in that there was an increase in the number of Board members responding to the survey that there are times when the Ministry and government interfere inappropriately in the work of the DHB.

The issue was also commented on the sections of the Board survey which asked DHB Board members to provide qualitative information on their experiences on a DHB Board. Question 2.1 provided respondents with the opportunity to indicate how they saw their DHB working to fulfilling their responsibilities for governance, accountability and decision-making. They were not invited to comment on specific items, but a number did so through marginal notes. This suggests a strength of feeling that should be reported. There were 32 marginal notes. The largest group (8) were associated with items b, g, h, u, and z(ii), reflecting a concern over the degree of central control by the Ministry of Health and government. For example, in rating item (h) regarding the extent to which the Board is a rubber stamp for management, two respondents commented that the Board was a rubber stamp for Government.

Board members were invited to respond to a series of questions on priority-setting in an attempt to understand the nature of the processes and barriers to achieving new directions. Having identified priorities, a number of issues were identified as barriers to achieving gains in these areas. The relationship with the 'Centre' was seen by 22 respondents as a barrier to making gains in priority area. Comments referred to the '*detailed control*' by the Ministry of Health and the costs of complying with requirements (eg reporting). Others related to the perceived absence of a coherent national approach with too many strategies and specifically to 'interference' by the Ministry and Minister in DHB decision-making (6 respondents). In relation to a question about implementation of priorities, four respondents commented on the Centre-DHB relationship, with comments such as 'Government restriction of public-private alliances', 'lack of co-ordination of Ministers at government level', 'diversion

of resources because of new demands of the Ministry’, and ‘Ministry dominance over the DHB’.

Similar comments were made in response to questions about experience as a Board member. Dominance of the 'centre' was a key issue, with 17 comments on this. Respondents indicated that the reporting requirements to the Ministry were too onerous and bureaucratic. Some suggested that the size of the Ministry could be reduced. In general there was an expressed preference for more local autonomy and some resentment that local decision- making was circumscribed.

Virtually all Chairs (who are appointed by central government) acknowledged the importance of an over-arching role of Government as funder and policy-maker for the sector. They recognised this may limit DHB decision-making from time-to-time, but there was no indication that this was seen as a major problem; more a part of normal public sector relationships. Some Chairs did, however, identify some restrictions on them in terms of decision-making, although none were considered serious barriers.

In the CEO interviews, a number of comments were made around the role of government and the Ministry of Health in decision-making. It was suggested the Ministry was more centrist than previously, and that the inability to make local decisions ‘*without the political “tick”*’ was common, compromising the DHBs’ ability to rationalise services and meet local needs. Several CEOs reported that the Ministry was too concerned with operational matters within DHBs and CEOs expected a more ‘hands-off’ approach and indicated that such involvement could cause difficulties locally. The overall size of the Ministry was also a cause for comment among CEOs.

In the case study research, the researchers found that in all five case studies devolution of decision-making to DHBs had been slower than expected. There was a general consensus that the DHBs would like more responsibility and autonomy. Most informants expressed frustration at the degree of involvement of the Ministry in operational policy setting at the district level and it was stated that there should be greater demarcation between DHBs and the Ministry of Health. Throughout the case studies there was a view that the Ministry’s role should be concerned with overall monitoring and policy development with operational decision-making left to the DHBs.

Concern was expressed that the Ministry of Health continues to be too involved in operational issues and has not '*pulled back*' to a policy role or changed its skill-set.

National NGO and professional organisation informants also made comments about issues relating to devolution of funding and decision-making, in particular around the tensions inherent in aiming for national consistency while also recognising the need for local solutions to local issues and to a desire for innovation at a local level.

The research revealed the extent to which these issues played out in practice, detailed in the following sections.

4.3.3.1 Devolution of Funding

Funding for the older disabled

At the time of the second round of interviews, funding for disability support services (DSS) for those aged 65 and over had been devolved to DHBs (in October 2003). Funding for DSS for those aged under 65 years of age remained the responsibility of the Ministry of Health. In key informant interviews, Ministers suggested that many DSS services are not in fact health care, as funding supports day-to-day living needs. It was noted in interviews that decisions about whether to devolve or not are made by the Ministers responsible, as opposed to the Ministry of Health. One key informant felt that funding should be further devolved – noting that it is difficult for NGOs where some funding and contracts are still with the Ministry of Health and some are with DHBs. Key informants noted the Ministry of Health concern about the interface where people move from one service to another; one senior official felt that services closely aligned with DHBs (eg, support services for medically fragile children) should be devolved, while other services not felt to be core DHB business should not. Examples of the latter included community-based services, day programmes, residential care and home-based services.

One concern with devolution related to having 21 DHBs contracting for care; and it was suggested by some informants that the system of having a representative team which reviews contracts and makes recommendations should continue in order to maintain national consistency and to move to a fair pricing model. Issues relating to national consistency were a key issue where, for example, providers have contracts not only with the health sector but also with the Ministry of Social Development, for funding the same service. Often, there are different criteria and accountability relating to such services.

A number of issues were raised around the actual funding devolution process for services for those aged 65 and over; these are set out in a separate report (on financing, purchasing and contracting). One key informant previously apprehensive about the funding being given to DHBs felt that DHBs had done a great job and, in relation to the Health of Older People's Strategy, were driving change ahead faster than if the funding stayed with the Ministry of Health.

In general Chairs were moderately optimistic about the opportunities presented by devolution, expecting that local monitoring would ultimately be more effective than national monitoring. One Chair commented:

'...every time we review a contract we find a stuff-up...no-one's ever monitored them, or looked at them...But it will be better now because it's local and you can monitor better, you know pretty quickly if things are going wrong out there' (C13).

In interviews with CEOs, ten volunteered comments that there were positive implications from the devolution for their DHB, including opportunities to work with providers, to find efficiencies, and to consider service improvements across the entire aged care sector.

In the case study research, the advantages of devolution of funding for DSS for those aged 65 and over were seen to be greater flexibility and fluidity in service provision to meet the specific needs of individuals and reducing boundary issues between services.

In two case study DHBs, informants expressed concerns about the split management of funding for people with disabilities, between DHBs and the Ministry of Health. In one DHB, the DHB felt it was carrying the risk of insufficient support and residential services for the younger disabled as a lack of capacity within such services creates pressure on DHB-provided services. Those under 65 who have both health and disability service needs would tend to be serviced by whichever service has the greater resources, rather than this being determined by what is clinically optimal. In two DHBs, it was expected there would be boundary issues around the two funding streams, particularly as those near in age demonstrate needs more akin to an older age group. Issues around access to services were likely to be heightened for Māori who tend to show age-related conditions prematurely relative to the rest of the population. As a result, some DHB informants would prefer to see funding and responsibility for services for those aged under 65 years of age devolved to DHBs. But non-DHB providers had concerns over shifting responsibility away from a Ministry of Health which knows the services well and where levels of funding for disability services could be swamped by funding requirements for other (ie hospital) services. Overall, there was a general acceptance across case studies that younger people with disability should not be seen through a health mind-set, and little pressure to change the status quo and devolve services for those under 65.

National stakeholders were also interviewed about the devolution of funding for DSS, following on from the devolution of funding. They reported that DHBs were poorly prepared, received inadequate information at the transfer and that there were shortfalls in funding. This was seen to have held up the transition, but informants noted that some DHBs were making progress in developing an integrated continuum of care. Informants were unanimous that services for the elderly were severely under-funded and suffered major recruitment and retention issues. Some boundary difficulties were seen to have arisen from the split management of the funds for the disabled, regarding the assignation of individuals to appropriate services.

National consistency was an issue in the interviews. Some services, such as the home support services, were identified as in need of sector reform but this was perceived as being more achievable if co-ordinated nationally. Research in one case study district highlighted the tension between standardisation of service specifications and addressing

local needs (more on this). It was thought that national consistency would be helped by more training and publicity.

Some informants acknowledged that the devolution of funding for services for those aged 65 and over to the DHBs has left some NGOs with a complex contracting regime. For example, a mental health consumer advocacy organisation holds a national contract for advocacy and support functions but this is held by a lead DHB. This national organisation has a deliberate policy of trying to avoid engaging with DHBs individually in order to keep a national perspective. For this organisation the national contract is to provide support, education and information. In addition the NGO has regional contracts around workforce development, plus local branches also have some local contracts as they perceive a need and respond with proposals. For example, one branch provides residential care to consumers and another provides community support workers. Furthermore, the organisation is run by voluntary committees in each of its 21 branches. Having local Boards creates issues for nationwide organisations which must influence multiple Boards to achieve national consistency and standards of service. One consumer representative organisation informant expressed concern that access to services may be an arbitrary locally-imposed criteria resulting in inequities.

One disability advocacy organisation informant considered it was too early to assess the impact of devolution, though one large DHB was apparently doing well developing the integrated continuum of care, while there were concerns about the more rural DHBs. For older people devolution could potentially promote the desired seamless care between health care services, including primary care, other support services, assessment and rehabilitation, and respite care. With regard to the coordination of services, one anecdote was reported from a person

‘who is older and disabled and who is making quite, quite extensive use of the various health services, that she does not yet, she doesn’t feel that the ship’s getting in wonderfully well yet. Things are still quite lumpy. And there is the additional factor, complicating factor of what part PHOs will play’.

However, this was considered to be due mainly to the resources being stretched and the organisations were still going through the transitional phase of adjusting to new ways of doing things. Overall this disability organisation was not getting strong positive or negative feedback about the changes introduced by the devolution to the DHBs.

Another informant thought the co-ordination of care between the short term personal care support, such as district nursing and the disability support services, home-based support and residential support, had improved since devolution.

At the time of our interviews, difficulties with the devolution process, meant that for some informants there had been little progress in relation to services for the over 65s, as providers were still waiting on the DHBs to catch up. DHBs were also arguing that they had had devolved to them an under-funded service, further potentially limiting developments in this area. Disability informants were unanimous in the opinion that services for the elderly suffer from the chronic under funding of residential aged care and home support services.

One informant spoke of NGOs having to educate the DHBs about the sector as they did not appear to understand the dynamics of running these services or just how marginally they are funded. For this informant *'if our occupancy drops below about 96% we start to lose money'*, and there was a perceived risk of the DHB trying to reduce the overall cost of elderly care by managing down the numbers.

NGO informants also observed some issues around the split management of the younger and older disabled population. According to one informant, disagreements have arisen between needs assessment service coordination agencies about who is responsible for whom. An NGO informant noted some of those in the under 65 group were more like those in the older group and vice versa, as a lot depends on the individual. This informant hoped in time there would be more flexibility to allow services that are appropriate to that person. There is also

'a very tricky boundary issue with younger disabled people as they age. They stay in the community, they still have care and younger peoples' NASC. If they go into residential then they go into the older peoples' NASC. And fundamentally within both of those areas there is argy-bargy between the NASC who is responsible, particularly if they are alike in age and interest'.

Fears were expressed that some people may slip through the cracks between the boundaries.

In relation to further devolution of DSS funding, in one case study DHB, some disability stakeholders and providers expressed the view that DSS should be regarded differently to mainstream health services. Full devolution of DSS funds was generally supported by DHB respondents but not by third sector providers. Informants noted the advantages devolution would bring to developing integration with chronic care services provider by the DHB. Providers could see the benefits in being able to develop closer linkages to DHB staff than they would with the Ministry. However, the broad view among disability stakeholders and providers was that DSS should be regarded differently to mainstream health services. There was little support from third sector providers for further services to be devolved to DHBs with one provider preferring funds remain with the Ministry as *'they know the services'*. They were worried that devolution might lead to decreased levels of funding if decisions were made at the DHB level and feared that disability concerns would be swamped by mainstream health concerns and budgetary pressures.

Some informants preferred to leave the management of the younger disabled within social services to avoid disruption and the preferences to not put a medical paradigm around people with disabilities.

One informant, however, much preferred local decision-making to working with the Ministry as *'we're still doing that in the young person's disability area and it's a dog's breakfast quite frankly'*. An example was given where the NGO was negotiating with the Ministry an additional service to enlarge the existing contract. Although the Ministry was committed to purchasing this service and the organisation was keen to provide it, negotiations were hampered by three changes of personnel in four months, with consequent constant efforts to re-educate and backtrack over issues previously

agreed. Furthermore, the service had been set up proactively with distinctive features that were key to its success, but when the contract was sent away it eventually came back two months later with the wrong client group and a number of standard clauses that had been specifically excluded by agreement. This informant acknowledged that national disability organisations have continued to be concerned about devolution, with the focus remaining on the potential loss of consistency, and that without ring fencing, the funds for the older disabled population may be absorbed into other aspects of the DHB operations.

Another informant considered this to be much less important than how the service is actually developed:

'In fact I would argue against moving it because it just creates a huge amount of disruption, slows advances in service delivery by at least two years while everybody sorts out the process and I mean we're never going to get it right ... what we need to work on is the coordination and the models of service, not which side of some sort of arbitrary dividing line that gets administered from'.

Another disability advocacy organisation informant agreed with the non-devolution stand, stating they and *'disabled people in general were quite alarmed at the possibility of disability services [for younger people] devolving to DHBs'*. Concerns included losing national consistency, placing disability issues in a medical paradigm, and the difficulty of keeping track of scarce disability equipment. They had *'made fairly staunch representations that we did not want the funding to go to DHBs because we have no confidence that they would be able to deliver'*.

A third disability informant observed there to be quite different attitudes and approaches with regard to the younger disabled as compared to the older disabled. He considered the younger disabled had been more successful in advocating for resources which he attributed to *'ageism in public policy'*, believed to be driven by fear of the financial impact of the ageing society. Older people are more numerous and have relatively greater medical needs and therefore are seen as getting *'a bigger slice of the health cake'*, although on a per capita basis they are not, or it is due to relatively greater medical needs. This informant argued strongly that philosophically and ethically there was no reason why older people should have lower standards of service

as compared to the under 65 age group, and the fact that this was the case was purely driven by dollars.

Public health funding

As with funding for services for younger people with disabilities, public health funding had also not been devolved to DHBs at the time of the interviews (and in 2006, funding remains with the Ministry of Health). Our research focused on the reasons for this and the advantages and disadvantages of funding for public health remaining the responsibility of the Ministry.

Key informants interviewed for this research noted how the NZPHDA model was to be increasingly focused on population health, adopting a public health approach. Ministers and officials were of the view that a more important question was how we should be '*doing*' public health.

Three out of twelve Chairs reported they were happy to see existing arrangements persist, while several more, who expressed an interest in devolved funds, were keen to ensure economies of scale were maintained and fragmentation avoided. There was however an indication that closer alignment between local and national priorities could be developed and several Chairs noted that local work with PHOs and priority areas such as diabetes could be strengthened with access to public health funds.

In interviews with CEOs, 13 out of 16 CEOs indicated a desire for greater devolution, with seven expressing strong views about the importance of being able to make decisions locally in support of PHOs. Among those expressing support for greater devolution there was also recognition of the need for some national public health initiatives and that there were definite efficiencies through regional collaboration. The three CEOs not particularly concerned about devolution expressed strong support for the regional arrangements of which they were a part. Others expressing similar satisfaction nevertheless would have preferred the funds to be devolved, even with ring-fencing.

Some case study informants also expressed impatience with the slowness of devolution of public health funds, particularly in the context of the goal of focusing on population health. In one case study DHB, key informants wished to see public health funds devolved '*the sooner the better*'. It was acknowledged that there are some essential national public health roles, but that overall there should be some urgency to complete the devolution process.

In one case study DHB, frustration was expressed that as a Board they are trying to take the big picture, an overview of services in the region *yet all* the money is not accessible to them. The non-devolution of public health monies was seen as problematic. '*Here we are in DHBs improving the health of our population but in the one area most fundamental to that it is still held centrally.*' Many wanted a clear commitment from Government regarding the devolution of public health funds, as the lack of devolution of all funds was seen as hampering local decision-making.

In a third case study DHB, it was recognised there was a complex structure where contracts remain between the Ministry of Health and local providers but a regional forum of DHBs has input into decisions about purchasing. In this Board, the priorities were for diabetes and cardiovascular health and as the DHB did not have its own health promotion services, it is reliant on regional processes to allocate resources consistent with these priorities. Interviewees in this DHB regarded DHB influence over national level public health decision-making as minimal. Opinions differed as to whether contracts for public health services should be held at the national or district level. Board members and senior management preferred the funding to be devolved, in order for there to be some consistencies in the allocation of responsibilities across the health sector. Reasons for keeping this funding at a national level included the need for national consistency in activities such as screening programme and the need to retain a critical mass of public health expertise in a single organisational setting.

In a fourth case study DHB, there were mixed views about the appropriateness of public health funding being devolved to DHBs. Staff within the DHB were generally keen for the funds to be fully devolved, so as to enable improved local planning and decision-making. This would also align with the refocusing of services towards prevention, and with the need to integrate some public health services into primary

health care. However some interviewees were of the opinion that it is appropriate for some public health contracts to be retained at the national level.

In a fifth case study DHB, opinions also varied about the devolution of public health funds, with some wanting to see the funds devolved immediately, given the focus of DHBs on population health, through to one informant who preferred to see DHB tasks being consolidated before the addition of other tasks to their role.

A separate piece of research on public health funding was undertaken in association with the Health Reforms 2001 Research. That research involved a literature review, particularly focused on the ways in which developed countries such as New Zealand organise public health funding, and interviews with the Ministry of Health, DHBNZ, and five non-governmental organizations (NGOs). Four of the five NGOs contract with the Ministry for the provision of services (a mixture of public and personal health services); the fifth had no such contract although it is a member of a broad-based coalition that receives Ministry funding.

That research found a mix of views in relation to the desirability of devolving public health funding. Some frustrations were expressed on the part of DHBs at not having public health funds while having a population-based focus, while others considered centralisation to be the most appropriate approach, in order to restrain transactions costs where national NGOs providing services would have to work with 21 DHBs were the funds to be devolved.

The considerations which drove informants towards the retention of centralised decision-making about public health service funding included the need to retain a whole-of-system view and whole-of-system leadership, the value of economies of scale in a small set of nationally negotiated contracts rather than a large set of locally negotiated ones, and the economies of scale that flow from retaining expertise centrally in a small country with scarce public health expertise.

The considerations which drove informants towards devolution included the desire by DHBs to adapt their services as a result of their unique information about their local populations' differing needs, the obstacles that the centralisation presents to DHBs in

exploring economies of scope across personal and public health services, the desire to deliver on their statutory responsibilities to improve population health and to promote the integration of health services² (undermined by the ‘signalling’ that perhaps the Minister didn’t trust them to carry out their statutory responsibilities), and the constraint to effectiveness represented by nationally standardised approaches to health education and promotion when DHBs across New Zealand have very different sub-populations.

4.3.3.2 The Role of Government Strategies

Many of the findings from the first round of the research around the role of government strategies were echoed in our second round of data collection. Overall, having national strategies to set frameworks continued to be highly approved of and was considered to give strength to the health system, although the real proof of their worth would be seen in results some years down the track. However, there were some weaknesses, including concerns over a one-size fits all approach, the lack of implementation processes in some cases, and the lack of resources to follow through.

In the second DHB Board member survey, the role of Government Strategies was acknowledged once again, with 88% of respondents giving some level of agreement that Government strategy plays an important part in Board decision-making, slightly higher than in 2002 (b).

Board members were also invited to respond to a series of questions on priority-setting in an attempt to understand the nature of the processes and barriers to achieving new directions. The factors influencing priority-setting for 2004/05 identified by DHB Board members, and of relevance to this theme, was Government direction, which was identified as an equally important factor in priority-setting as financial considerations (78 respondents, 29 specifically mentioning the requirements of the Primary Health Care Strategy and PHOs as important determinants of local priority-setting). There was, however, also a strong view (40 respondents) that local planning processes were important in determining priorities through the HNA,

² As set out in S.22 of the NZ PHD Act; also see Appendix 2

strategic and annual planning processes, planning days and workshops, and Board-management agreements. A focus on community health needs and the need to reduce inequalities was mentioned by 26 respondents, and the special needs of Māori and the requirements of the Treaty of Waitangi were mentioned by 8 respondents.

Having identified priorities, a number of issues were identified by DHB Board members as barriers to achieving gains in these areas. This included the relationship with the 'Centre', which was seen by 22 respondents as a barrier to making gains in priority area. Comments referred to the '*detailed control*' by the Ministry of Health and the costs of complying with requirements (eg, reporting). Others related to the perceived absence of a coherent national approach with too many strategies and specifically to '*interference*' by the Ministry and Minister in DHB decision-making (6 respondents).

Questions then followed on in relation to barriers to *implementing* desired priorities, although there was some confusion over this question. Barriers to implementing change included, amongst other things, the Centre-DHB relationship (4 respondents), with comments such as '*Government restriction of public-private alliances*', '*lack of co-ordination of Ministers at government level*', '*diversion of resources because of new demands of the Ministry*', and '*Ministry dominance over the DHB*'.

In the Board member survey, respondents were invited to make any general comments they wished about their experience as a Board member. One of the themes that emerged was dominance of the 'centre' (17 respondents). Respondents indicated that the reporting requirements to the Ministry were too onerous and bureaucratic. Some suggested that the size of the Ministry could be reduced. In general there was an expressed preference for more local autonomy and some resentment that local decision-making was circumscribed.

Overall, DHB Board members reported a range of comments in the surveys in relation to their experience as a Board member; some noting their experience as a positive challenge (9) and others as persistent frustration (15). Some respondents expressed extreme frustration, for a variety of reasons, including all the issues expressed

throughout the survey and reported here. For some people these clearly represented overwhelming barriers to progress and high levels of personal frustration.

In interviews with DHB Chairs, most acknowledged the importance of the New Zealand Health Strategy and particularly the Minister's '*start here*' list in determining local priorities. A few Chairs also noted that these, especially the '*start here*' list, can limit local flexibility. Several Chairs indicated that their DHBs had explicitly and consistently indicated priorities for public health and primary care, target areas such as diabetes, or areas '*unhooked*' from the hospital, reflecting the New Zealand Health Strategy or the Minister's list. All Chairs endorsed the PHCS as visionary and important for the effectiveness of the population approach and outcome orientation of the New Zealand Health Strategy. Several were more optimistic than they had been two years earlier and all reported progress in coverage of the population.

Informants in several case study DHBs suggested that their own plans and priorities reflected those of central government, and in some cases it was noted that this prevented there being concerns over conflicts between local and central priorities. For example:

- In one case study DHB it was commented by the researchers that: 'Our assessment is that the 2004 HNA is a well-presented and research-based document featuring the Government's health gain priority areas'.
- In the same case study DHB, it was reported that the planning documents were overall reflective of government health strategy. It was reported here that having national parameters already set is useful, providing these do not conflict with local issues and needs. In this DHB, government strategies were overall seen as helpful, but there were always issues between the centre and the local DHBs in assessing need and priorities.
- In a second case study DHB, the national strategies were key, and in some cases, it was suggested that these should drive, or be built into the DHB's DSP.

- In one DHB it was reported that the DHB's Māori plan and Pacific plan closely reflected the Government's strategies for these groups. In another case study DHB, an informant from a Māori provider organisation commented the Government Strategies '*were the closest we have had to our own philosophy, that is holistic approach, greater access, and focussing on population health rather than just face to face doctor-patient interaction*'. In another case, a number of respondents commented on the commonality between Ministry and DHB priorities regarding primary care.
- In one DHB, the overall priorities were considered to be similar to those of the previous year. Furthermore, the locally assessed health needs and priorities were reported not to be significantly different from those identified by the national health strategies, thus avoiding any major battles over national priorities versus the local priorities.
- In another DHB, by the time of the second round of interviews, informants expressed the view that while their planning documents were compatible with the overall New Zealand Health Strategy, new strategies or reports coming out were now considered with more equanimity than previously. One informant described the difference:

'we might look to see how it fits with what we're doing but we don't suddenly start steering the waka in a different direction...we know that if we're going to make progress we've got to keep paddling straight ahead and we'll get there'.
- In one case study DHB, it was noted that although the Minister and Ministry sets national policy frameworks, the DHBs adapt these to the local community so that the '*DHB sets a localised flavour*'. One informant observed the DHB personnel are always talking to people in the community, which allows the DHB to be more innovative in the ways they create local solutions. For example, the strategies for care of the elderly were tailored to the local health needs of the older population, which '*worked quite well in delivering outcomes*'.

- In this same case study DHB, one informant described *'how generally, national strategies and associated working groups have assisted DHBs with the implementation of policy etc'*.

Informants raised a number of concerns, however, in relation to national strategies:

- This support was often mixed with scepticism and frustration that the money was not always available for implementation. One case study DHB informant spoke of the New Zealand Health Strategy (NZHS) as *'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'*.
- In another case study DHB, it was reported that good ideas coming from the centre were incorporated into the DHB's plans, but it was also noted that these new ideas rarely come with funding attached. It was also noted that it was distracting if directives occurred in the middle of a financial year, although it was reported that this was occurring less often than previously.
- In one DHB, it was acknowledged that the strategies should drive or be built in the DHB's DSP, but it was also felt that the DHB cannot do all strategies at once. For one informant, at the end of the research period, there were still too many strategies. Other informants in a second case study DHB agreed, noting that particularly for a small DHB it was impossible to implement them all, and the lack of time and people resources would mean some would inevitably languish. One made a strong plea for focussing on just a few things rather than trying to do everything, and there should be no new strategies for at least a year. *'It's a time to just calm down and consolidate, do a good job of what we've got and then move on'*.
- One informant suggested that once the government strategies were incorporated into DHB planning and were put out for consultation, there was a danger of *'re-writing Government policy, and re-prioritising'*.

- In one DHB, a comment was made that, although the strategies are important, a times they felt that at times national strategies '*can be a barrier*' to district decision-making or can actually slow down local implementation and limit local responsiveness. This informant acknowledged the need to know how funding was being spent and to have some sort of consolidation and rationalisation and coordination, they were also adamant that they would like to see DHBs given more autonomy and undergoing less detailed monitoring by the Ministry.

NGO informants also supported having national strategies to set frameworks and this was considered to give strength to the health system. However weaknesses were seen as '*trying to make one size fit all*', the lack of implementation processes and the lack of resources to follow through.

The PHCS came to much more prominence during the research. The PHCS elicited strong support from throughout the sector, albeit with concerns relating to implementation. In one DHB, the control by the Ministry was also seen as problematic. One informant recognised the rationale for having a degree of control in relation to large sums of government funding being spent in primary health care. However they felt that '*if it's going to be successful then there needs to be a lot more letting go, letting the money come out to DHBs and then the DHBs making decisions about what to do about primary care with their local communities*'.

4.3.4 The Role of Central Government in Funding and Planning Decisions

As in the first round of data collection, the involvement of central government in funding and planning decisions was a key issue for many of those we interviewed.

Virtually all Chairs (who are appointed by central government) acknowledged the importance of an over-arching role of Government as funder and policy-maker for the sector. They recognised this may limit DHB decision-making from time-to-time, but there was no indication that this was seen as a major problem; more a part of normal

public sector relationships. Five Chairs reported no real constraints on decision-making. However, nine Chairs indicated restrictions had been put on to them, with concerns around lack of funding for new policies or programmes that DHBs were expected to introduce; about the Minister's 'start-here' list limiting local flexibility; around the need to break-even financially limiting attempts to work with even the 'start-here list'; and concerns the right balance had not yet been achieved with a need to challenge the Ministry from time-to-time. Chairs also had a view that DHBs are over-governed and over-monitored, and this was associated with a desire for more local autonomy. Chairs recognised that DHBs are spending public money and need to be accountable for this but *'we still want more flexibility and would like them to leave us to do more things'*.

In the CEO interviews in the second round of data collection, all CEOs reported that their Boards had engaged in some form of priority-setting, even if only examining local needs in relation to national strategies. However, almost all CEOs were also concerned to point out that even when there was a strong desire to make changes to existing services, there were significant barriers to this.

One of the significant barriers was that some of these decisions had to be made at ministerial level and were seen as highly politicised and not always following the DHB's recommendation or preferences:

'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'. (CEO 10)

CEOs also acknowledged the impact of other factors on decision-making, and this included that stopping or withdrawing services was also contentious with the community and clinicians.

Fifteen CEOs commented on the role of the Ministry in relation to policy development and decision-making. With respect to developing policy, ten CEOs acknowledged the importance of this role and the extensive range of strategies available, but some commented on the need for attention to co-ordinated policy across directorates, especially given the large number of strategies. Discussion with CEOs through DHBNZ over the policy development programme was welcomed.

'The Ministry sets a framework to operate within. In some ways different aspects of the Ministry contradict each other in the sense of so many policy issues happening at once. So once you have nine or thirteen priorities it gets a bit complex and I'm not sure that the link between those different areas is woven together' (CEO 10).

'I feel as if we are trying to do too many things - the country, the DHB, the Ministry, and the more things you do the less focus you have' (CEO 3).

With respect to local policy decisions, seven CEOs specifically indicated that they felt that there was definitely too much central control of decision-making. It was suggested that the Ministry was now more centrist than previously and that the inability to make local decisions, *'without the political "tick"'*, was common, with this compromising DHBs' ability to rationalise services and meet local needs.

'The reality is that the Minister has a lot more under statute than existed under the old model. The extent of control coming out of the centre is much stronger than it was' (CEO 20).

'It's now 2004 and we District Health Boards. We now know who we are, what we are and what we should be doing. There should be much less direction and monitoring from the Ministry, it shouldn't be such a big player'. (CEO 12).

Issues around monitoring were a key concern in the second round of interviews. All 19 CEOs who commented on monitoring reported it as still fairly demanding. Three CEOs noted no major problems – *'We don't have any problems with them'* (CEO 14). Eight reported improvements over the last year or two. The regime was reported as rationalised somewhat, but still quite bureaucratic or managerialist in style, with little focus on outcomes:

'There is increasing clarity, but we're not there yet' (CEO 15).

'Some of it's a bit bureaucratic, but on the whole monitoring is not too much of a problem' (CEO 9).

However, eight CEOs expressed frustration at the system, suggesting that the requirements needed to be focused on more meaningful indicators, that feedback to DHBs was needed, and that more progress had been expected in this important area.

'They haven't moved to the new sector structure in their philosophy and thinking. They have not yet come to grips with the fact that they should be monitoring at a higher level....it's imposing huge additional costs on the sector'. (CEO 5)

While the comments above reflect the varying expectations of individual CEOs, there was also a divergence of views that seemed hard to reconcile, given a common framework. On the one hand:

‘...yes, there's certainly been an attempt to rationalise the number of reporting mechanisms and all the data that needs to be reported back’ (CEO 19),

and, on the other:

‘They are definitely over-monitoring and more things get added each year’ (CEO 18).

Several CEOs reported that in the Ministry was too concerned with operational matters within DHBs, including working directly with PHOs, NGOs, and in mental health. CEOs expected a more *‘hands-off’* approach and indicated that such involvement could cause difficulties locally.

In general, the overall size of the Ministry was a cause for comment among CEOs. One pointed out that the *‘Ministry has more capacity to generate work than DHBs have to undertake it’* (CEO 1). Within this context the DHB model was referred to as *‘devolved in appearance but not in reality’*, and there was frustration with the central constraint on decisions that were seen to be more appropriately made locally.

In the second round of interviews, a few CEOs also commented on the role of the Ministry of Health in implementing the PHCS. Some specific concerns related to direct negotiations between the Ministry and providers, leaving DHBs *‘out of the loop’*, cutting across their relationship with PHOs and undermining their continuing role. It was also reported that the Ministry had unrealistic expectations of the capacity and capability of primary care to fulfil requirements within the timeframes set out, which placed unreasonable burdens on PHOs.

Similar sentiments were expressed in the case study research. In one case study DHB, some informants felt that certain aspects of the health structure required more rather than less central control, for example, the planning of tertiary services and information technology. However, across all case study DHBs the research has shown that informants feel that the balance between central and local decision-making is still not optimal, with a need for more local autonomy, especially to increase the possibility of local innovation.

In one DHB, informants commented on the general '*slowness*' of devolution, characterised by the statement that the Ministry was '*...still mixed up a lot with what the DHBs are doing*', and that this had inhibited the development of true accountability.

In another, there was a widespread view that it would be preferable to have more autonomy and less detailed monitoring by the centre, which would enable local decisions to be made and implemented '*in a much more timely fashion*' and with greater ownership. An increase in autonomy was predicted to improve the view of the working relationship between the DHB and the centre. The Ministry was seen as an intrusion and the extensive monitoring '*sets up conflict management*'.

Various complaints were made about the Ministry from informants in this district who considered that the Ministry should more clearly delineate their areas of responsibilities, seen as policy development and monitoring, and leave the implementation to the DHBs.

Some informants also considered there to be excessive central government control, sometimes politically-determined. In one case study DHB, the flexibility of the DHB on purchasing decisions was seen by some as constrained by the Ministry: *'They are very intrusive in how we spend our money'*. In this DHB, it was noted that although the Minister and Ministry sets national policy frameworks, the DHB adapt these to the local community so that the *'DHB sets a localised flavour'*. One informant observed the DHB personnel are always talking to people in the community, which allows the DHB to be more innovative in the ways they create local solutions. For example, the strategies for care of the elderly were tailored to the local health needs of the older population, which *'worked quite well in delivering outcomes'*.

Preference was expressed for greater devolution to the districts. Political constraints were seen to limit the degree to which DHBs were able to be responsive to the preferences and priorities of the local community. One informant considered that local people:

'are always going to have greater knowledge of what the locals needs are and the local people are the ones that are going to have to carry out the projects, (they) need to have an input... a degree of ownership... for them to be able to actually make it work. It's never going to work when someone in Wellington says this is your priority when the local people don't believe it is a priority, well they're not going to make that work are they'.

Another informant echoed this position. They felt that people based in Wellington could not make decisions for what people in a particular DHB actually need. They felt interference from the Ministry and that the Ministry would not get this right. Community input was seen as enabling a better approach. One informant also commented that:

'The relationship with the Ministry would improve if they just recognised that people doing the work on the ground probably have a better idea. And they many only need to consult with us a bit and listen to us instead of trying to direct us from afar'.

The following issues were noted in this context:

Mental health ring-fencing – In two case study DHBs, ring-fencing for mental health was seen to be problematic. In one, ring-fencing was 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. In a second DHB, the ring fenced funding for mental health was criticised by some as a specific example of Ministry rigidity. It was considered local people understand service needs better and should not be directed in this way. It was thought central Government put money into silos, as they were worried that not enough would be spent on mental health. However this informant thought because of the strong community links within mental health, money '*goes further*' whereas money does not go nearly far enough in surgery. One informant argued that if a district wishes to spend more on one part of the sector than another, then the DHB should have the freedom to make that decision. The transparency and accountability to the community was seen as a sufficient check to ensure appropriate decision-making.

National contracts – In one DHB, a view was expressed that while there has been devolution of responsibility and accountability, in areas where national contracting exists, there are problems for local financial and service management. For example, with the devolution of Older Persons’ funding, there are provisions in the CFA regarding the actions required of the DHB, even though the aged residential care contracts were negotiated nationally with no DHB ‘*sign-off*’ where a DHB preference for a time limit on these arrangements was not accepted. Similarly the national contract for dentists was seen in one DHB to preclude it from developing local arrangements which may improve dental health for children in that district. In this DHB, informants did recognise a need for elements of national consistency, but felt that nationally negotiated contracts continued to limit the flexibility of the DHB where it wanted discretion to vary funding. It was also recognised that this very flexibility might put other DHBs at risk, however. The example provided related to dental care, where a national negotiation process was seen to disadvantage the dentists in this district, with dentists exiting service provision, and an unfair burden being placed on the remaining dentists. However, if this DHB increased the price, other DHBs would also be affected. Informants reported that without greater flexibility, the DHB would have difficulty in achieving the desired service improvements, however.

National policies and programmes – In one case study DHB, one informant noted as an example of national control of decisions, a directive to meet laboratory worker pay demands, because this DHB was seen to be holding up a national settlement. They also pointed to the case where extra funding was provided for orthopaedics services. This funding was taken up, although comment was made that ‘*the money may have been better spent elsewhere*’. In another case study DHB, it was suggested the DHB does not always have the flexibility to make decisions based on local information because of the constraints placed by the Ministry of Health. One respondent suggested that if the Board was directed towards national priorities, such as the orthopaedic initiative, then these should be funded outside of population-based funds. In a third DHB, an example was given of where the Ministry of Health directed the use of certain high-cost cancer drugs, and while it initially supported these with funding, in the ensuing year it was up to the Board to fund the patients on those drugs.

In a third case study DHB, informants expressed a tension over the perceived lack of willingness by the Ministry to devolve decision-making. *'They've said on the one hand the DHB must make all these decisions but then they've proceeded to make some decisions for us, definitely they've interfered'*. This informant was dismissive of the ability of academics based in Wellington to make sensible decisions for what people in their district need. The high priority health needs targeted such as diabetes, hypertension, asthma, skin and heart disease are not in dispute with the Ministry, *'but we fear interference from the Ministry will tell us how to do it and I don't think they will get it right'*. With regard to implementation, *'I think we can do that much, much better with community input and collectively work it out than someone sitting in Wellington'*. Another put it more bluntly: *'The relationship with the Ministry would improve if they just recognised that people doing the work on the ground probably have a better idea. And they may only need to consult with us a bit and listen to us instead of trying to direct us from afar'*.

Some spoke of the DHB trying to manoeuvre to avoid the Ministry interference, particularly as the DHB moves out of the establishment phase and starts to assert itself more. It has prompted the DHB to *'move faster than they can think and define what we are going to do'*. Another expressed resistance at the direction from the Ministry, that it was okay to be directed by the Minister *'but not some level three flunky'*.

PHO implementation – In one case study DHB, PHO implementation was cited as an area where there was conflict between central and local decision-making. This DHB felt that it has been undermined in a number of ways in discharging these responsibilities, and that the Ministry has maintained tight control over decisions related to PHO implementation. For example, it was reported that many of the *'rules'* were *'hidden'*, with proposals rejected by the Ministry when they appeared to be within guidelines. This was exacerbated, according to informants in this and in a second case study DHB, by the way in which primary health providers, who were used to working at national level, could go to the Ministry if they were unhappy with a particular DHB decision. Local IPAs, for example, appeared to recognise that power still lay with the Ministry and not the DHB, and the Ministry, according to DHB informants, did nothing to support the DHB or change this approach. Informants recognised the importance of the Ministry articulating PHO policy clearly and

facilitating developments. However, it was felt that there was considerable inflexibility in the national PHO workplan and a failure to recognise local situations and workload. For example, Ministry workshops on governance, team building and Care Plus were described as *'rolling on'*, regardless of the state of readiness of particular PHOs and the appropriateness of timing. Promotion of PHOs in the wider community was seen as *'little, too late'*, with the eventual Ministry of Health advertising campaign regarded as poor and misleading.

In another instance, one case study DHB had assessed that that an establishment group did not require the amount of establishment funding they had requested, but this advice was ignored by the Ministry. This was reported as *'irritating'* for the local funder to be over-ruled, for what were assessed to be *'political reasons'*.

Another example was where the Ministry has requested proposals for primary care mental health. *'Locally we want to grow providers but now the policy around primary care and primary health organisations has changed to this is the way that we're going to do business'*. This was seen as setting a trend of funding providers through PHOs whereas the DHB had been trying to grow providers. There was some concern the smaller providers might be *'swallowed up and changed'* as funding increasingly becomes channelled through PHOs. Some concerns were also expressed that some providers might be coerced into PHOs, which may not be their preference, although the stated national policy is that organisations voluntarily become linked to PHOs. This was seen by some to make the providers vulnerable to the decisions of the GPs, as the register of enrolments, and therefore the funding, is directly linked to them.

Tertiary hospital risks – Some informants in one DHB felt that the Ministry of Health did not fully appreciate the risks, financial and other, of being a tertiary hospital. DHBs receive directives from the Ministry, but there is not always the recognition of the impact these have locally. Our informants recognised that the Ministry is working with political imperatives whereas the emphasis locally is on managing a deficit within the context of a tertiary service. One informant suggested that the Ministry and government, by devolving services, have shielded themselves from having to make rationing decisions.

Service volumes – In one case study DHB, these were seen as dictated by the Ministry of Health, even where there is uncertainty about how well this equates with the needs of the local population. The system here is seen to be capping funding. It was recognised that the new approach has more transparency in terms of where the funding went however this transparency is seen to come with costs. In one case study DHB, a clinician’s perspective was that allocation of resources was still running more in terms of service volumes dictated by the Ministry, but there was uncertainty about how well that equated with the need of the local population. *‘To some extent we can provide information and insight into what is required - I don’t think managers are excluding us from it, it’s just that the system is capping funding’*. This informant contrasted this with the earlier health delivery systems where the hospital did what it saw fit for the local community, but *‘money disappeared down a big black hole’*. Now there is more transparency but that also has its costs.

Problems reconfiguring services – In one DHB, two informants indicated that withdrawing from services was difficult because the Ministry’s approval was required. One explained:

‘Our experience is that, when we start to suggest that we might withdraw from a service, there’s not a lot of enthusiasm for specific proposals from the Ministry, as distinct from the general concept of reallocating money, and... the larger the organisation which you want to reconfigure, the harder it is’.

In another case, it was reported that with the consultation process to plan the restructuring at a particular hospital, the Ministry declined to become involved until a later stage, then exerted pressure over decisions already made. In a third case, it was noted that the Ministry response to suggested withdrawals in the DAP typically included comments from several parts of the Ministry of Health, *‘less than enthusiastic about the particular proposal, and each pushing different barrows’*. The process was not tested, for example, by pushing ahead with proposed cuts in spite of Ministry objections.

Engagement with DHBs on major policy issues - There is an understanding in one case study DHB that the Ministry does not formally consult on major issues until these have been approved by Cabinet. Previously, when consultation had taken place earlier, DHBs had been seen as involved in the development of policies that

significantly affected their roles. An example given was the second Mental Health Plan where the DHB was concerned that there were implementation issues that needed to be discussed much earlier.

Performance Monitoring and Management – Many comments were made about performance monitoring and management. Examples include those set out below.

In one case study DHB, informants reported that overall they saw the sector as being ‘*over-monitored*’, with additional requirements each year. Much of the information reported was not actually required locally. Providers reported on the overlap between DHB audits, Ministry certification and contract reporting. In general, it was felt that it would be more helpful for the Ministry to require a smaller amount of high level reporting than negotiate details of performance in all areas. National work on reviewing the balanced score-card was seen as very valuable in building up some significant clinical and outcome measures and the Ministry’s leadership role in this was commended.

In one DHB it was commented that a key constraint on planning included the Ministry of Health’s requirements. The DHB noted what cannot be done within the operational policy framework and service coverage schedule and it was suggested that the service coverage document was increasingly more detailed according to one informant, with service specifications and detailed expectations. The effect was that prioritisation decisions were already made and there was little point to the whole DHB infrastructure, community involvement and strategic planning. This included the mental health blueprint, which is also very detailed. It was also noted that there are occasions when the Ministry makes decisions which cut across a DHB’s DSP and DAP.

In this same DHB, it was felt that the DAP process was the weak part of the planning process, as it was so very much concerned with Ministry accountability. One informant commented that the form and ‘*even sometimes the words are dictated by the Ministry*’. In relation to the DSP, this same informant felt that although it may be seen as a DHB document, the Minister had to vet it and the Ministry set such a tight timetable that this informant reported no DHB could meet the timing requirements.

In relation to performance management, the Ministry requires DHBs to report quarterly on various measures either in narrative or numeric form. The accountability requirements were identified by several informants in one case study DHB as time-consuming, *'daunting and confused and not helpful; onerous, too numerous'* and sometimes silly. An example cited was the requirement to report the *'number of Māori women giving up smoking in the first trimester, second trimester and third trimester of pregnancy'*. The informant asked rhetorically *'Where is my dataset going to come from; the local dairies...?'*. Similarly the nursing structure had to be reported every quarter, but the informant had never heard of a hospital that changed its nursing structure every quarter. This mass of accountabilities existed, they felt, because the Ministry had not yet sorted out its own internal business. Fewer but more meaningful measures were needed, according to many informants throughout the research period.

Furthermore, the given accountability indicators incorporated assumptions about causality that were not always valid, according to an informant involved in reporting. Here the size and structure of a DHB's population could throw up unrealistic results when it came to reporting on certain indicators and comparing DHBs. An informant believed that the accountability measures for NGOs were more robust than those for the hospital.

DHBs, according to an informant in this case study DHB had a vested interest in being monitored. But this informant believed the Ministry should get out of *'micro monitoring'* of DHBs, and that monitoring should be the responsibility of an independent authority. Such an authority would be able to assess where any weaknesses in the structure arose: with policy, funding or implementation failures. With the current structure, the Ministry ended up with the roles of *'judge, jury and executioner'*. One informant thought the Ministry should be downsized by about one quarter; removing this number of staff would remove the Ministry's capacity to micro-manage the DHBs, and *'liberate [the Ministry] to focus on the big picture'*. One informant felt the various accountability requirements could work differently:

'I think the annual plan is our accountability document and the Crown funding agreement should be reduced to one page...: We give you money and you will deliver on your annual plan.'

Another felt that a more *'flexible', 'open and trusting'* process was needed, along with better understanding by the Ministry of what happened at the grass-roots level in DHBs.

In another case study DHB, there was a widespread view that it would be preferable to have more autonomy and less detailed monitoring by the centre, which would enable local decisions to be made and implemented *'in a much more timely fashion'* and with greater ownership. An increase in autonomy was predicted to improve the view of the working relationship between the DHB and the centre. The Ministry was seen as an intrusion and the extensive monitoring *'sets up conflict management'*.

One informant referred to the DAP as an example where the Ministry requires a large amount of information, particularly regarding current systems and processes. This was considered confusing and detracting from the purpose of the document, which is to plan the foreseeable future, whereas the Ministry requirements were perceived to be *'mixed up with monitoring'*.

In one DHB, it was noted that DHBs are now required by the Crown to inform the newly formed National Capital Committee of intended capital expenditure regarding property, buildings and major equipment over a certain threshold. In addition, any decisions of this nature need to be considered by the regional grouping of DHBs. These policies were acknowledged to promote coordination and rationalisation of expenditure, but were also observed to slow down the DHB's processes.

There was consistency amongst respondents' views in this case study DHB that the Ministry's reporting requirements have continued to increase and a widely held view that monitoring is excessive. One respondent described this as a significant issue for the DHB as the reporting takes a lot of management time and attention, rather than that time being spent on *'developing and improving future health services'*. Others made similar comments: *'I think we over monitor, or, if it's not over-monitoring, we're certainly monitoring too many things or in the wrong place'*. Another saw the monitoring as getting in the way of being innovative as it keeps them focussed on the past. This person expressed frustration at the futility of some requirements, which *'could be slimmed down quite considerably'*.

There was a preference for reducing the volume of reporting by reporting on fewer things *'that was finer in detail and was still telling a story of what you're seeking, whether it be in terms of the services delivered, the financial results or whatever'*. Other suggestions were for the Ministry to stick to their timeframes more rigidly, define the mutual responsibilities of the Ministry and the DHB more clearly, and to hold more face-to-face meetings.

In another case study DHB, it was suggested that the Ministry monitors the DHB excessively, according to one informant. The Ministry requires the DHB to report quarterly on accountability indicators, monthly financial reports, staffing reports, against a reporting template and an annual report. This system has been going for two years was due for review, according to one informant, who thought it would be difficult for the Ministry to compare DHBs as they are all so different in population, geographical size, and urban/rural mix. Another was critical of the reporting systems as *'deficient'* because the focus was on reporting against existing contracts or service delivery, whereas in the Act the DHB is charged with monitoring need and addressing it.

Some spoke of wanting reporting and monitoring to focus on health outcomes, patient satisfaction or what difference the contact makes rather than processes and inputs. One commented the bare statistics does not capture, for example, the provision of a service where the patients have no transport and the doctor needs to go to them. One informant would like to see less paper-based monitoring and more on-site

observation, and that there should be a genuine attempt to capture health outcomes rather than numbers of contacts or outputs. It was noted that at least one of the provider organisations contracting directly with the Ministry is evaluated by a team of evaluators sent out from the Ministry rather than relying on reporting data.

In this case study DHB it was noted that the reports required by the Ministry are sent to the funding agency based in Dunedin then the reports are made available to the DHB. Although this provider thought it was likely the DHB did read them currently, *'I wonder how long it will be before they stop reading them as well'*. Given the shared goal of achieving health outcomes and reporting on that, this process reporting was seen as *'ridiculous'*. The time and resources required for this type of reporting was seen as an impediment to the development of systems to capture *'the real things you want to capture,'* although they were able to record some of the *'important things like immunisations'*.

The accountability reporting requirements were reported in this case study DHB as being very prescribed. One informant stated at times there has been a consultation process around what should be reported *'but in our experience it doesn't make any difference whether you offer any comments or not.'* There was recognition that the Ministry is driven by the Governments priorities and does not have much leeway. The accountability requirements were seen as problematic because of the time and effort taken up with reporting. One cited a \$50,000 contract requiring a ten page report with about fifty reporting lines on it, which were unlikely to be read.

Comments relating to central and local decision-making were also made in interviews with professional organisations. One informant commented on this, noting there is a conflict between trying to get nationally consistent access to specific operations, with a set of criteria that would decide whether or not it was clinically appropriate for someone to have an operation or not, and what was affordable for some DHBs where *'we have a much higher threshold which is a financial threshold'*. The variability around the country creates inequity.

A number of informants also made comments relating to issues of national consistency vs local decision-making. One NGO commented on the potential conflict between national funding models for palliative care and negotiating contracts with a local DHB. The DHB is trying to move away from it because they feel they haven't been resourced to be able to support the national funding model. The NGOs are negotiating about how much deviation is acceptable and are liaising with Hospice New Zealand.

There was also concern that services for older people under the devolved system would be changed away from national consistency. One informant argued:

'there's a whole lot of new services that could evolve under the health of older people strategy ... just got to find that balance between national consistency so that clients, staff and providers can kind of expect a certain level of equity between regions, and flexibility so that you can actually be creative enough to come up with innovation in your local area ... where it's a fairly standardised service being provided with fairly standardised inputs and measurable service delivery with measurable quality standards then I think there's a very strong argument to maintain national consistency of pricing'.

Residential care fees, rest home care and geriatric hospital care were all considered to be in the category of needing national consistency. On the other hand, where innovative approaches are developed for a specific community in response to the demographics and community dynamics, then a regional or district solution was considered more appropriate. One NGO observed that DHBs were placing different priorities on similar levels of assessed need, with unequal resource allocation for that service in different parts of the country.

The ability for local decision-making to promote innovation was another common theme. One mental health informant strongly endorsed contracting at a local level because it offers the freedom to come up with innovative and local solutions whereas regional or national solutions were associated with *'one size fits all'* approaches.

A tension was noted between local solutions and national directions and framework with regard to nursing roles. For example, innovative nursing roles are being developed within PHOs, but at the same time, are creating overlap with other existing services. In one respondent's view:

'There should be some professional control of that in the interests of simplicity/avoiding fragmentation/linking those roles up with education ... We don't want to stifle development, but we also don't want to end up with this complete national mess where nobody knows who anybody is any more'.

In relation to professional groups, the local input aspect of the model was viewed positively but it was questioned whether DHBs had real autonomy or whether the devolution of decision-making had been over-sold. How much local autonomy and power the model actually gives DHBs was a moot point, as expressed by this informant:

'In the early stage, 2001, it felt to me almost as if the model was being over-sold – you know, communities will have the authority, the power and will be able to solve our problems and I thought, "That's not going to happen". Not that quickly anyway, and it hasn't happened. I think it could go a bit further and more quickly than it has. There is still a reluctance I think to trust DHBs to do things and maybe to make some mistakes ... Every now and again you read comments from a DHB Board or a member saying they're frustrated they aren't able to do much at all, and that would be my observation. The Boards have got less room to do things differently than they probably should have. So I think local input is important. The structure is developed to deliver it but the processes I don't think are really there yet'.

4.3.5 Number and Size of DHBs

A key issue throughout the research relates to the appropriate number of DHBs in a local, or devolved, model. As this report has already shown, it was frequently suggested that there are too many DHBs. Key informants stressed during the research that there would be no forced amalgamations between DHBs, but they also felt that it would be important for some DHBs to be working closely with other DHBs. For example, smaller DHBs were thought to need to share services with larger DHBs (eg, in mental health), but the issue was also raised in relation to the three Auckland DHBs, working together closely already in terms of, again as an example, mental health.

Some of the issues raised by key informants in relation to the number of DHBs included:

- Recognition of the importance of community ownership for the funding arm, but a suggestion that issues relating to community ownership do not arise in relation to the provider arms
- Noting that if the Auckland DHBs merged this would be a third of the country and they would be huge DHBs; and querying whether there would be sufficient buy-in at a local level
- A suggestion of very little savings from mergers
- That DHBs can and are working together; a lot could be achieved through collaboration and regionalisation
- Queries over whether amalgamations would really work; with one key informant reflecting that forced amalgamations do not work, although voluntary amalgamations would be fine
- Smaller DHBs really needing extra funding
- Support for local engagement but queries over the provider arms and whether DHBs should buy in some services/share services; the key is the DHB holding the budget for their local population services rather than providing everything themselves
- Wanting the focus to be on doing things better, not reorganising
- Recognising current regionalisation processes in mental health, public health, surgical services and cancer treatment and wondered if this might raise questions about the number of DHBs
- Recognition that for organisations eg third sector organisations, working across DHB borders and having to work with a number of DHBs must be tricky and that developing relationships does take a lot of time
- A question was raised by one informant about the capacity and capability of having for example funding and planning functions spread across so many DHBs and whether there is enough capacity and capability to do the '*hard grunt stuff at the front end*' (KII R2).

A few Chairs volunteered that the system had been established with too many DHBs, but none suggested forced amalgamation of Boards. It was suggested that ways could be found to move towards greater rationalisation and regional activity, but without undermining current governance arrangements. The local focus was strongly endorsed: *'a sense of community ownership again'; 'a local focus for all health services', with 'increased public confidence' in the system overall.*

In the second round of interviews, of the 16 CEOs commenting on the size and number of DHBs, all identified problems with the large number and variable size of DHBs. The responses to questions on this issue were extensive, and CEOs had clearly thought about this a great deal and discussed it with their colleagues. Smaller DHBs were seen as disadvantaged by both infrastructure costs and the inability sometimes to ensure good clinical services. It was suggested that 21 separate DHBs is a barrier to achieving strategic change.

However, it was strongly argued, without exception, that amalgamation was not necessarily the solution to these problems, either by combining small boards or merging small with larger boards.

'...but you can't get away from the communities of interest and parochialism that exists in New Zealand. So I actually wouldn't change too much...'
(CEO 3)

'...size has a lot to do with being viable... but even some medium-sized boards are struggling....but this issue is beyond administrative savings and whether we will actually make any difference to health care delivery. I would say 'no' [to amalgamation]'. (CEO 14)

There was absolutely no support for forced amalgamation and it was anticipated that no DHB would volunteer to be merged with another (*'no turkey ever votes for an early Christmas'*). As noted above, there were seen to be benefits of local approaches to needs assessment and strategic planning, despite higher costs. It was pointed out that being the actual provider of services was not essential to being a DHB, with several CEOs suggesting a dual system whereby small boards undertake planning and funding roles, but with larger boards supplying hospital services. Another view was that if amalgamation did take place, funds from smaller DHBs could be ring-fenced for local areas:

‘I think there could be slightly fewer DHBs but you could dispense with a board and have a general manager and ring-fenced budget’. (CEO 3)

There was a widespread view among CEOs that recognised a strategic change in the DHB environment – characterised by emerging alliances – that will continue to develop and moderate the effects of having a large number of boards.

‘There's other ways of achieving good results by amalgamating some functions...there's amalgamation of a lot of functions...there's a lot more collaboration than there used to be’. (CEO 11)

‘Right now, the [A] and [B] boards are busy talking about looking at regional service delivery. Now, whether that means that there will be two DHBs or one eventually - who knows? But in terms of service provision we will see a seamless entity’. (CEO 9)

‘You don't have to amalgamate boards. You can achieve the same things (savings, sharing expertise, etc) in a different way and still maintain the real philosophy behind DHBs, which was local responsiveness and local ownership.’ (CEO 5)

Similar issues were raised in the case study research. Many informants across all case studies considered there to be too many DHBs, creating an overly costly administrative structure. In one case study district, informants suggested that many DHBs are recognised as being too small, and that there are too many DHBs. Several informants felt there would be major efficiencies if some DHBs were to amalgamate; suggesting that more real effective collaboration was needed between DHBs. In another case study DHB, informants also reported that there are too many boards, with smaller boards seen as lacking the capability and capacity that the DHB model demands. *‘It was reported to be “frustrating” for larger DHBs to have to fill gaps for smaller ones and it was considered that 21 DHBs is unsustainable in the longer term’*. However, this weakness was seen as allowing sensitivity to local issues.

Having 21 DHBs was seen as unsustainable in the longer term, with some informants highlighting the potential gains in efficiency if DHBs were amalgamated. Smaller DHBs were seen to suffer from the diseconomies of scale as they still have to fulfil the same administrative demands and reporting requirements as DHBs.

Informants also raised issues around transactions costs in dealing with a number of DHBs. One informant noted that in their experience multiple contracts with a number of DHBs increased transaction costs including time, computer information management systems, and personnel costs to manage all the different information and reporting requirements. On the positive side, *'having your eggs in lots of baskets'* gave some security.

National stakeholder informants interviewed in the second round similarly expressed concern about there being too many DHBs, resulting in split capacity and leaving each DHB with insufficient capacity to solve problems; too much money lost in infrastructure; NGOs having to relate to 21 DHBs; and a duplication of effort by DHBs likely to take money away from services. There continued to be concerns about loss of national consistency and standards. Particular concerns were raised in relation to access to services, with a local focus acting as a barrier to the development of national solutions and strategies applicable to all DHBs, with 21 DHBs a barrier to influence by NGOs. Lack of consistency in contracting was also seen as a concern. Second round informants were also concerned about the reforms as having held up necessary sector development and it was also observed that devolution had been accompanied by greater regulation. Informants considered that real gains would be achieved through implementation of policies and strategies, rather than structural change. In spite of these concerns, there was also strong support for having a local approach, which was seen to enable local input, allow more flexibility and innovation and allow for greater ability to think about integrating services at a local level.

4.3.6 Capability and Capacity

In the DHB Board member survey 'free text' responses, one-fifth of respondents reported their initial training had been very positive, suiting their needs, with the Institute of Directors' courses highly regarded. DHB Board members identified a range of areas where greater training would be appreciated, including in relation to funding and financial matters; a more formal orientation to the DHB; more specific governance training for the health area; more detailed introduction to health issues; and on the health system, the government's perspective and the Ministry's role.

All fourteen respondent Chairs felt the capability of their Boards had improved over time, becoming more confident and having a more sophisticated understanding of their issues. In some cases, this had taken considerable effort on the part of Chairs to achieve this, however.

As noted earlier, CEOs had relatively low expectations of the performance of their Boards in the first round of data collection. Concerns were expressed over financial skills and depth of knowledge of the health system amongst elected Board members, although the community knowledge and networks of elected members were valued. CEOs were grateful for the presence of appointed members.

In the second round of interviews, six CEOs were very positive about their Board; thirteen felt their Board had settled into a well functioning mode, albeit with considerable input from the Chair and the CEO. Only one CEO felt that the Board lacked understanding of both the complexities of health and the accountability processes.

One of the issues raised in interviews with CEOs was concern over the commitment of resources required in relation to HNA and strategic planning processes for smaller DHBs. National stakeholder informants in professional organisations similarly queried whether all DHBs were sufficiently skilled to do HNA and prioritisation processes, for example. National stakeholders also considered that funding and planning skills are relatively scarce, and are now split between the 21 DHBs. Poor capacity in this area was seen as a barrier to realising the potential gains from greater consultation and engagement.

Similar issues were raised in the case study research. In one case study DHB, it was noted that small DHBs are required to do the same tasks as larger DHBs but with a much smaller capacity. Reporting requirements, attending to the correspondence from the Ministry, information management and utilisation, and financial management were all noted as under pressure or else prone to succession problems as one person leaving makes a proportionately large reduction in resources to deal with the ongoing demands. The number of Government health strategies to implement was seen as problematic for

all but particularly so for small DHBs. Because of the smallness of the management structure, managers fulfil more than one role in a smaller organisation. In one case study DHB, for example, the CEO oversees the day to day operational management of the provider arm as well the funding of the health services of the district, whereas larger DHBs would have separate managers for these arms, thus avoiding an additional layer of management.

In a second case study DHB, it was noted that the capacity and capability for funding and contracting has been built up and was regarded at the time of the second round of interviews as fully staffed and well resourced. However, there were still shortfalls in the planning expertise, which were managed by the use of external contractors, rotation of staff and the development of training opportunities. The DHB was considered to have the capacity to manage the devolved contracts for the services for the older disabled.

In the second round interviews, one informant noted the need for NGOs to fund national training in the devolved contracting environment. Another NGO informant thought the funding and planning capacity of the DHBs was stretched beyond its resources and so could not resolve the problems facing them. These resources are relatively scarce and have been split between the 21 DHBs. *'They're all basically having to find solutions to the same problems 21 times over'*. The model of 21 DHBs was thought to prevent the DHBs from really solving the issues facing the social services sector, with particular reference to the aged care services: *'The expectation that we would have in terms of services being developed and issues being solved, they're fundamentally constrained from delivering on that'*. Without that capacity the potential gains from more consultation and engagement with those knowledgeable in the sector, such as through the DSAC committees, could not be realised, according to this informant. It was thought the service development would be better progressed at regional level discussions.

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. The strategy was *'relatively high level ... someone has to do some work in the*

middle to make the translation'. It was thought there should be some mechanism to bring people together regionally or nationally '*but there isn't the mechanism really. Because they're all really just struggling to keep their head above water in their own region or their own DHB they have to attend to that*'. The strategy was seen as '*great, but it's quite a long way from what we're doing now and I don't think there's really been enough thought put into ... what needs to change and ... how would we see the services being for the future*'. The capacity and capability to do significant service development was seen to be lacking in the Ministry, and the scarce resources were further spread amongst the 21 DHBs' funders and planners. However, it was also acknowledged '*there are some pockets of amazing activity in the midst of all that*'. One DHB was seen as having put '*some real energy into their age wellness*'. One informant observed Boards could choose to focus their scarce resources on an identified priority area and achieve some forward progress, but that it was difficult for a DHB to progress all areas at once.

4.3.7 Collaboration between DHBs

In the second round of data collection there were again a number of examples of collaboration between DHBs.

4.3.7.1 District Health Boards New Zealand

In the second round of interviews, all Chairs spoke very positively about the role of DHBNZ. Its operations were reported to have become more streamlined since 2002/3. Overall DHBNZ was seen as improving the '*connectability*' of the sector and giving confidence and stability through times of change.

Specific areas where DHBNZ was seen to be working well were:

- *In facilitating relationships with the Minister.* While several Chairs noted that they saw their primary relationship with the Minister as a one-to-one accountability on behalf of their DHB, most appreciated the quarterly meetings with the Minister arranged through DHBNZ, and the collegiality that this brought.

- *Industrial relations.* Several Chairs indicated that DHBNZ had made an important contribution to industrial relations, particularly with respect to moves towards national agreements.
- *Technical issues.* Analytical and policy work on sector-wide issues (eg pharmaceuticals, IT, referred services) were seen as making important contributions to the capability of individual boards, as well as developing common approaches.
- *Facilitating regional collaboration.* Chairs spoke very positively about the regional groupings fostered by DHBNZ, with regular meetings of Chairs and CEOs considered important for developing regional approaches to issues, including capital developments, service configurations, regional clinical issues.

Despite the positive comments, a few Chairs expressed disappointment in DHBNZ and felt that it had potential to be even more effective. One issue was the diversity of levels at which DHBNZ was required to operate, political, operational and technical, spreading resources thinly. There was a view that DHBNZ could foster collaboration even more.

In the earlier round of interviews Chairs had expressed some concern about the need to maintain an effective governance relationship within DHBNZ to ensure that the autonomy of individual Boards would be preserved. In the second round of interviews, this was seen as less of an issue, with some Chairs indicating that the organisation was evolving appropriately: *'the Chairs are more comfortable now'*; *'there is a good relationship between the DHBNZ board and the executive group'*. However, a significant minority of Chairs still expressed some reservations about DHBNZ's way of working, for example:

'I don't think it's working yet as well as it should be; I think there's more collective benefit to be got out of it. I am broadly comfortable, except DHBNZ needs to be in better communication with Chairs' (C 1)

'I have a concern that it is leading DHBs, not following' (C 12)

'It has a long way to go at governance level to work properly' (C 8)

'Still a danger of becoming an elite group' (C 4).

In the second round of interviews 18 CEOs responded to a question about DHBNZ. Although there might have been some tensions and difficult moments, DHBNZ is firmly established and well-regarded by CEOs. Its position as a ‘*servant of the DHBs*’ and not an independent voice has been confirmed, and there were appreciative comments from CEOs on its work in a number of areas: industrial relations, national issues such as pharmaceuticals, workforce, etc. It was commended for the technical and analytical capability it brought to issues, its liaison with the Ministry on behalf of DHBs and the way in which it had stimulated regional approaches to collaboration. The regional approaches around the country varied to suit local requirements.

Some caveats remained, particularly with regard to ensuring that DHBNZ does not present itself as representing DHBs without a proper mandate, although several CEOs noted that other health agencies tended to misunderstand DHBNZ’s role and ascribe to it powers or responsibilities it does not have. Some DHB members reporting concerns were also seen as not fully understanding the agreed role.

‘There are a number [of members] of our Board who believe that DHBNZ is usurping some control of governance, and it's got quite testy at times.’ (CEO 1)

‘There are tensions within DHBs over DHBNZ. Those tensions are from the uninitiated ...or people who are not fully engaged at regional or national level....You hear people talking about DHBNZ as if it's running its own agenda. So it frustrates me a bit. If we don't like the agenda, we reset it...and we don't and shouldn't view it as a problem’. (CEO 8)

In the case study DHBs, similar points were noted about the role of DHBNZ.

In one case study DHB it was reported that the chairs of one regional grouping met monthly, usually by phone, discussing issues such as funding, deficits, PBFF and shared services. The regional approach was considered by one informant to work well in areas such as accounting systems, IT, and insurance. It was also reported that regional CEO, chief operating officer and planning and funding counterparts from different DHBs met separately. For example, one planning and funding manager met twice a month with counterparts in the region, and less frequently with others outside the Central region. These groups had standing agenda, rotating chairing and set themes for each meeting. While there were moments of tension, it was reported that

there was primarily camaraderie and collaboration. As time went on the DHB got more value from DHBNZ, according to an informant. Another indicated that the links through DHBNZ were becoming '*more useful for us than is the Ministry*'.

DHBNZ activities included co-ordinating work on the multi-employer collective agreements (including the nurses MECA), analysis and modelling, and collating work on tertiary hospital funding issues. Another reported role, under the DHBNZ umbrella, was where planning and funding staff from a number of DHBs worked together informally on analysing material for the operational policy framework and service coverage schedule, according to one informant. While small DHBs might benefit from this work, most of the work was done by the larger DHBs (none from the South Island) whose planning & funding staff had known each other in RHA or HFA days. But it was a DHB's skill-base and willingness to contribute that dictated how much work it did on behalf of other DHBs, according to another informant. A further informant favoured combining the planning & funding units at a regional level. Overall, DHBNZ's role became clearer over time, informants felt, and by the end of the period, indicated that it was working better and better, and gaining the confidence of the Ministry and Minister.

In a second case study DHB, the role of the DHBNZ was noted to have changed over the research period. This increase in activity was considered to be not a change in role but arising in response to changes in the environment. For example, contracts with various providers were devolved to DHBs but it was deemed desirable in some situations to keep a national organisation to also support industrial negotiations. Workforce development was another area of DHBNZ activity that was perceived as having a lot of impact. However one respondent observed '*We have to be careful [DHBNZ] don't actually take on too much but I think they're certainly involving themselves at a greater level on national issues of interest to most DHBs and that's positive*'. There were also slightly mixed views over the role of DHBNZ as a national negotiator of contracts. One expressed a reservation that in reality the issues are often different between the DHBs.

In a third, small case study DHB, DHBNZ was seen as invaluable, as it allows participation in working groups on topics of concern and interest to DHBs. One example given was of contracting with a key group of providers, and the DHB clearly welcomed the ability to work with other DHBs to get their heads around the issues. It was also reported that DHBNZ takes up issues on behalf of the DHBs with the Ministry, for example, relating to what they saw as a rigid boundary between personal health and disability support services, decided on the basis of diagnosis rather than personal need, generating a situation for some high need clients who *'fall through the cracks'*. Regular reporting from DHBNZ (on a monthly basis) was seen in this DHB to allow the Board members and others who attend to keep in touch with a wider range of issues of policy and operational significance that is the focus of DHBNZ activities. Again, in deciding to work collaboratively with other DHBs, the lack of autonomy of Boards was raised as a potential drawback, as was the alternative of not being included in collaborative decision-making.

With a larger case study DHB, it was noted in the first round that DHBNZ was considered to have *'an evolving role'* and to be a useful co-ordinating body for the DHBs. At that time, DHBNZ was reviewing its role, having completed an establishment phase, and there was a perception that DHBNZ was ready to address some key issues and bring consistency across the sector in terms of both information sharing and action. In the second round of interviews, these aspirations were reported as being realised, particularly in terms of national contracting and projects. These allow the CDHB to *'get a sense quickly of what is happening around the country'*. In general it was reported that the work of DHBNZ has allowed greater co-ordination and connection between the Minister, Ministry and DHBs. Support was noted for the work done by DHBNZ on benchmarking and pay equity between hospital and community sectors.

Some caution has been expressed by informants in this same case study DHB regarding DHBNZ. It was reported that there have been occasions when larger DHBs (contributing larger amounts to DHBNZ) have been ‘*out-voted*’ by smaller ones. It was also noted that there is an almost infinite amount of work that could be done by DHBNZ and that priorities need to be set more tightly. There was also uncertainty about the extent to which DHBNZ is trying to be too involved in too many issues, or whether it should concentrate on fewer ‘*big ticket*’ items.

4.3.7.2 Shared Services Agencies

Most Chairs commented briefly on their local shared services agency. The agencies appeared to undertake two quite diverse roles on behalf of DHBs; first, research and analytical tasks for which some DHBs had limited capability; and second, audit functions for contracts let to a variety of NGO and private providers, including the recently devolved residential care sector. One Chair reported that the agency was extremely pro-active in alerting the DHB to problems.

Smaller DHBs were more appreciative of the agencies’ role, recognising that to incorporate the functions within the DHB would be difficult:

‘there would be problems without it; we would need .3 of a person in a specialist area!’ (C 9)

Larger DHBs reported that the immediate value to them was less obvious, but that they could use the agencies effectively.

Similarly, in the case study research there was strong support for the Shared Services Agencies and recognition of the work they do. The different roles undertaken by SSAs stand out as a key issue with particular case study DHBs.

In one case study DHB, it was felt that a contracting role for the SSA was an advantage in really understanding issues for DHBs. In a second case study DHB, the role was seen to involve '*significant analytical support*', including in regional service planning and some auditing. The SSA was seen to offer advantages in sharing scarce capacity and capability with concomitant economies of scale. Positive comment was made about this SSA's contribution. One informant observed that there is sometimes difficulty in sharing these resources with the other DHB co-owners because of the disadvantages of not always agreeing with their work priorities or work direction. Another stated the SSA was sometimes distracted by national processes. However, overall, those who commented on the SSA were positive about its role.

In a third case study DHB, there was some indication that the SSA role was being reduced over time, in part because of the DHB's vision of '*local, local, local*', and hence trying to do more and more itself, and to provide employment opportunities in the region. Even then, however, there were several areas where the Board sees the ongoing involvement of the SSA as essential.

In a fourth case study district, the case study DHB perceives its relationship with its SSA as very positive. This SSA began initially to administer DHB contracts, but over time has also increasingly become used as independent forum through which the member DHBs can work together to develop a regional approach to service planning and to generally strengthen regional collaboration.

In a fifth district, through the SSA and a Regional Forum, the DHB initiated discussions on clinical services throughout the whole South Island. Approximately 70 staff, including clinical and management personnel, from the six South Island boards attended, with discussions around the regionalisation and more appropriate management of orthopaedic, paediatric and cardio-vascular services. An important driver for the development of clinical networks incorporating smaller DHBs is the need for those boards to fulfil credentialling requirements.

4.3.7.3 Other DHB-DHB relationships

Besides the regional meetings under the auspices of DHBNZ, Chairs also reported bilateral relationships with local DHBs. Overall, relationships between DHBs were described as ‘cordial’ or ‘very good’ although several Chairs noted that there are still ‘slightly competitive’ elements inhibiting collaboration, and sometimes significant tensions, particularly between large and small DHBs over issues such as inter-district flows:

‘I initiated a set of principles and those were passed and re-confirmed at our last [regional] face-to-face meeting...It was an agreement that we would look after the concerns and be advocates for the community we look after, for our particular areas, but then we would look region-wide to get cooperation and collaboration and better value for money, better clinical services and so on. I believe it’s working very well and the last meeting was the most productive that we have had’. (C 4)

‘We have one tertiary hospital in the regions that provides regional services. I think there is some tension there. They like to be in control so we have some tensions. But that doesn’t mean that we don’t work well together. But I think they see themselves as going out and doing our work instead of truly providing a regional service into which everyone has input. So I think there needs to be some change of attitude, although that is often at a clinical rather than CEO or board level’. (C 1)

Some Chairs saw their DHBs as having very close relationships with their neighbours (*‘we now have a memorandum of understanding’; ‘we stand and fall on our relationship with each other’*). Although it was acknowledged that collaboration *‘is required of us’*, most acknowledged the benefits of such an approach. One Chair, however, felt that progress had been too slow in moving towards collaborative purchasing.

Sixteen CEOs commented very favourably on the development of positive relationships with other DHBs in their region and noted that these had been enhanced by DHBNZ regional groupings. Relationships had tended to develop in two broad areas. First, in relation to non-clinical and administrative services, where there was a trend reported towards increasing co-operation in support and administrative areas in order to derive greater efficiencies and increase capability. Human resources, industrial relations, IT and a joint venture laundry service as well as the shared services agencies were examples of such joint activities. Second, relationships had

developed in relation to clinical services, where several CEOs commented that the main risk to the New Zealand health sector is the non-viability of clinical services in some areas, and the need to develop relationships to sustain these. This was seen to be in the interests of both smaller boards, where recruitment and the achievement of critical mass might be problematic, and larger boards which needed certainty in terms of the demands placed on them from elsewhere. Examples of collaboration of services included mental health, surgical and medical specialities, and laboratory services. Some CEOs commented on the importance of clinical leadership in developing the necessary relationships and networks to further collaboration in service areas, and the variability of progress because of this. Good clinical coverage was seen as the important outcome, rather than efficiencies.

There was strong endorsement of these developments from most CEOs (*'strategic alliances are the only way forward'*) although it was noted that collaboration was made easier where there were similar board cultures.

'...it's always been good [working] with Board X; we work together really well...we seem to have similar values about things....But we can still work with [Board Y] on a project-by-project basis'. (CEO 3)

This area of collaborative activity had placed significant additional demands on CEOs but was nevertheless reported as highly desirable. Collaboration on clinical and other service issues were clearly differentiated from amalgamation of DHBs or any changes at governance level.

Examples of collaboration were also given in the case study districts. In one case study DHB, it was reported that the DHB had significant relations with other DHBs through formal lead-DHB arrangements but also through a range of other connections. Co-operative arrangements had developed around regional services, such as cardiology, neurosurgery and other services with another DHB, with which there were also cooperative relations in IT; and mental health services with yet a further DHB. Apart from concerns about pricing, relations were reported early in the period to be very good, but later, the issues around inter-district flows became extremely concerning. The tertiary services/inter-district flows issue was noted by informants as a top priority later in the research period.

Concerning lead-DHB relationships from a non-DHB provider's point of view, the notion of 'lead-DHB' took a while to develop: one informant noted that although one case study DHB was the lead-DHB for various contracts, the other DHBs involved liked to have a presence at contract discussions. Similarly, from the outside, providers found it 'easier' to deal directly with the non-lead-DHBs. One informant spoke of lead-DHB roles as involving responsibilities that were '*quite complex and potentially quite a burden*' given that a lead-DHB had to begin contract planning well in advance, and to carry financial risk.

In this same case study DHB, a particularly close working relationship had developed on Pacific Health issues, both at a local level with a neighbouring DHB's Board members, but also with Pacific managers from the seven DHBs with relatively high Pacific populations meeting every two months.

In one case study DHB with a close geographic position with a second DHB, informants reported constant contact between the two DHBs at the CEO and hospital management level, including second-tier managers; planning and funding; and other staff, including the Medical Officer of Health. Work was done on managing referred services between the two DHBs, in relation to public health contracts and on a *whānau ora* model. There were also Board relations with a third DHB. In both cases, some hospital staff members were rotated between the DHBs.

In this case study DHB, the downsides of some DHB-to-DHB relationships were seen by informants as:

- removing the Boards' decision-making autonomy
- adding to paperwork
- increasing the number and length of additional meetings.

Overall, however, informants favoured increased contacts with other DHBs and many looked forward to a time when there would be fewer DHBs than the 21 created by the NZPHDA 2000.

In a second case study district, collaborations were reported to have grown over time through the national and regional bodies and with other DHBs within the region, particularly those contiguous with the DHB's borders. Collaborations were over such issues as service configuration, capital planning, mental health planning, regional employment agreements and other regional issues where co-ordination is deemed desirable. One informant commented on how helpful the informal contact with colleagues from other DHBs has been.

One informant in one case study DHB added a cautionary note that the pressure to collaborate can place too much pressure on DHBs. This informant felt that collaborations do not necessarily mean an advantage for every participant.

In another case study DHB, collaboration with other DHBs was seen as a way of reducing costs by bulk purchasing of commodities, *'that's been a big saving and there will be a lot more of that'*. DHBs were also reported to be banding together to broker more favourable insurance terms. There was also reported collaboration in relation to *'regional planning on services such as rheumatology, renal, cancer'* and also working together in IT and mental health. There were, however, some tensions noted. For example, there was a recognition that all DHBs were under the same pressure to save money and to get as much revenue in as possible, and this raised tensions where the provider DHB seeks as much as they can earn for a service, whereas the purchasing DHB wants the service as cheaply as possible without compromising quality. In some cases, it is not possible to shop around.

In a different DHB, relationships with other closely located DHBs were particularly important, including in relation to inter-district flows. In this DHB, the CEOs and board Chairs meet on a monthly basis. According to one interviewee:

'These monthly regional meetings have been very good and we seem to have made progress. The difficulty is it's very hard to change the competitive model and there are still traces of that competitive model'.

Informants in this DHB reported quite different dynamics in its relationships with other DHBs. With one DHB, where there is not a shared geographic boundary, as well as two rather different philosophies, the two DHBs generally work very well together.

In contrast, this DHB's relationship with a neighbouring DHB was described as problematic. A central focus of this DHB's relationship with the neighbour DHB has been finding a satisfactory way of dealing with inter-district flows. Although the three DHBs are increasingly doing more work collectively, relationships remain strained.

In another case study district, in the previous research round we noted that there were still uncertainties in the evolving pattern of collaboration between DHBs in the South Island; although work was progressing well on a number of projects the limits of collaboration had not yet been tested. In this second round informants reported that progress had been made in working with other DHBs: with particular efforts to work with a neighbouring DHB in developing sustainable ways to support a range of clinical services, including general surgery, anaesthetics and paediatrics. Collaboration on information systems has also occurred across DHBs.

There are some tensions noted because of the number of boards and their highly variable size and capability. There is concern on the part of the this DHB that, as a large board it can be '*outvoted in some forums*' and that it is not able to secure value for money in its participation in joint activities, including SSAs.

4.3.7.4 Regional Mental Health Networks

Early on in the reform process, DHBs were directed to work together regionally in mental health, and to establish Regional Mental Health Networks (RMHNs). A separate report has been produced on these networks (Goodhead and Cumming 2005), which includes reference to an in-depth study of how the networks have developed and perceptions of their strengths and weaknesses (Goodhead and Cumming 2005). The material below is summarised from the first report.

The four Networks are the Network North Coalition which includes the Northland, Auckland, Waitemata and Counties Manukau DHBs; Midland RMHN which includes Waikato, Lakes, Bay of Plenty, Taranaki and Tairāwhiti DHBs; Central RMHN which includes Capital and Coast, Hutt Valley, Wairarapa, Hawkes Bay, MidCentral and

Whanganui DHBs; Southern RMHN which includes Canterbury, South Canterbury, Nelson-Marlborough, Otago, Southland and West Coast.

All four networks play an advisory function in the sector, with each coordinated by a manager or regional director, and each with a membership that includes a representative from each of the DHBs. The Networks vary in the degree to which they incorporate other sector stakeholders and the emphasis placed on consultation with the wider stakeholder community.

An early review of the RMHNs found the networks were focusing planning and funding allocation activities with a secondary function of providing an additional conduit for consultation with consumers, in addition to the DHBs' general consultation processes and specific processes relating to mental health. There appeared to be a risk of duplication of mechanisms already set up within the DHBs for planning and consultation, resulting in increased transaction costs and increased burden from participation for consumers and other stakeholders. The focus on funding and planning was seen to potentially be at the expense of attention to the more systemic issues which DHBs need to address collectively, including workforce development, managing the interfaces between services, leadership for recovery approaches, developing effective service configurations, clinical oversight across DHBs, and evaluation against recovery outcomes. A further risk was the potential for the RMHNs to drive a wedge between service providers and the management structure within DHBs, thus undermining one of the potential advantages of the current DHB structure, ie brokering links between funders and providers.

The findings from this early analysis were supported by our own research. One sector informant (interviewed mid-2004) observed that the RMHNs have evolved around a planning function but have not gained traction around service delivery. Furthermore, the proliferation of planning arrangements was considered to actually create tension between regional planning, the local advisory groups, statutory advisory groups and DHB Boards. This observer noted that regional and local planning priorities do not always coincide. This sector informant also highlighted the mixed views throughout the sector regarding the need for the RMHNs and the value they add. Advocates of the RMHNs point out the Networks have promoted access, whereas critics point to

clumsy and expensive infrastructure, and suggest that collaboration occurs regardless of the regional arrangements and is not dependent on the existence of the RMHNs.

We found quite mixed views about the RMHNs in our research. Of the fourteen DHB CEOs who commented on this issue (interviewed early 2004), seven CEOs were positive about the contributions of the RMHNs, two expressed concerns about their effectiveness or thought they were not very useful, three CEOs did not know or declined to comment, and two CEOs expressed reservations about the structure and accountability aspects.

Those CEOs who found the RMHNs useful noted a number of contributions. The RMHNs were seen as promoting access to regional services; providing support to mental health staff; promoting collaboration; providing mechanisms for planning, advice and consumer and provider participation, at a regional level; promoting regional consistency; and providing a platform for joint funding of regional planning processes.

However, some CEOs did not find the RMHNs useful. CEOs raised concerns over the RMHNs where they act as a separate entity, with the Ministry going directly to them, confusing accountability and where RMHNs are imposed, seemingly 'upstaging' the district, where they result in there being too many consultation groups where the consultation does not translate into nuts and bolts planning, and where they lack a mandate and lack teeth. Other CEOs referred to the ongoing struggles to get the structure right. At the time of our interviews in mid-2004 there were impending reviews in two regions.

Of the four DHB Chairs who commented on the RMHNs, three did not think they contributed a great deal, while one admitted not knowing whether they contributed or not.

Key informants interviewed in the case study districts also noted the role of RMHNs in their districts. In one case study district, the RMHN was expected to assist with communication and co-ordination given the importance of acknowledging the regional scope of decision-making with respect to mental health services. However, it

was noted that the RMHN was not a decision-making body itself. In a second case study district, the RMHN was also seen as a way of collaborating around planning and a forum for debating issues, but again reservations were expressed, including that the RMNH in that district was too cumbersome. DHBs were noted to be accountable for local service delivery but not for regional service delivery and it was recognised that not all participating DHBs have the same needs.

In the first round of interviews conducted with national stakeholders in early 2003, the two mental health sector informants reported that the RMHNs were not working well. Reasons given were that it was a 'talkfest' where the provider arm dominates, with a lack of real sharing attributed to the residue of competitiveness from the previous purchaser/ provider culture; and that there were too few consumer representatives.

Second round informants, interviewed mid-2004, gave more positive reports. One informant, representing a mental health sector advocate organisation, saw regional collaboration as the way forward. The objectives of the RMHNs were defined as giving a strategic view, sharing resources and ideas, ensuring access to secondary services, and to provide a mechanism for cooperation and information sharing. This informant assessed the RMHNs as delivering some benefits but as not giving the strategic direction desired.

A mental health NGO provider informant also gave a more positive account of the RMHNs, which were observed to have good communication networks, establish good collaboration, to facilitate information exchange, promote joint projects and act as a 'brake on some of the more outrageous projects,' and were helpful in raising issues. The consultation networks established by the RMHNs enabled a wider group of people to have input incorporated into planning processes. Weaknesses were noted including a lack of teeth to really effect change, proliferating planning arrangements, sometimes regional and district priorities were poorly matched and not all RMHNs included consumer input. The dissatisfaction with this latter aspect was independently emphasised by an informant from a consumer advocacy organisation.

A more recent review of regional mental health arrangements (Goodhead and Cumming 2005) found similar mixed opinions. In that study a sample of three CEOs (interviewed early 2005) questioned the need for these separate regional arrangements which are unique to mental health. They also pointed out there is no legal foundation for the regional networks which are not covered by the NZPHDA legislation. Whereas DHBs are accountable against the DAP in the legislation, the status of the regional plan is ambiguous and there was reported to be a lack of acceptance of this additional regional layer by some CEOs. Other concerns raised by key informants in that research were the extra costs imposed on the sector by this additional bureaucracy, that it perpetuates the notion that mental health is different and therefore not integrated with the rest of the health sector, that it created lost opportunities by dividing off some discussions into separate forums which would be more advantageously debated by DHB executive teams or Boards, and that the RMHNs potentially generated disconnection between local and regional planning. Furthermore some ventured the opinion that DHBs are now capable of collaborating without special or additional mechanisms imposed by central Government.

However, even the key informant critics in this research process acknowledged some significant benefits of the RMHNs, which were seen as allowing a platform for collaboration on pooling resources, sharing ideas and innovations. Regional discussions allowed the DHBs to address sector-wide issues more efficiently and effectively, and helped integrate the sector. Some of the “big” issues addressed (which are not easily dealt with at a district level) are sharing scarce clinical skills to promote equitable access, workforce development, developing information systems, tele-psychiatry and promoting optimal workforce attitudes to support recovery for service users. Some saw the RMHNs as potentially instrumental in driving standardisation, more consistent quality of care and to promote best practices. In relation to Blueprint planning, there was a great deal of optimism and anticipation of significant advancement of new specialist services as the regional plans are implemented. There were also perceived to be other gains arising from the enhanced collaboration between DHBs, such as greater integration and sector coherence between providers, the generation of more innovative and dynamic approaches, and the opportunities for regional training.

Although some features of the four RMHNs were more conducive to achieving some objectives than others, the research concluded that a prescriptive approach was deemed not desirable because of the different historical and geographical context each Network operated in. Furthermore, even though doubts were expressed by some participants whether the benefits outweighed the costs, Goodhead and Cumming (2005) concluded the costs of the RMHNs should be regarded as investment towards “soon-to-be-realised” much larger gains which will augment the more modest actual benefits generated so far. Many participants were enthusiastic and optimistic about regional service developments which were then in the early stages of implementation. Participants also concurred with the views of the key informants over the more general benefits of the RMHNs. Other models of collaboration were considered as possible alternative systems for achieving the desired objectives, particularly the sharing of scarce specialist skills across regions to ensure all have access to quality specialist services as needed but Goodhead and Cumming considered on balance the RMHNs should continue, to allow time to implement the service developments which have already been planned. They also recommended that the confusion over accountabilities be clarified, ongoing funding paths be defined beyond the Blueprint funding model, and that greater support should be offered for change management processes. Since this report was completed the Mental Health Commission has made itself more available to the sector where help is requested (personal communication, Mental Health Commission).

In summary, stakeholders throughout the sector perceived some benefits of the RMHNs: to facilitate more equitable access to regional services, to promote collaboration and the sharing of resources and skills, to allow wider stakeholder involvement, and to provide a platform for the development of a regional shared vision for planning and the to address strategic issues. The criticisms focussed on the confusion about accountabilities and responsibilities created by the RMHNs, that they lack power and are therefore not very relevant, the added layer of costs, and the excessive consultation making unwieldy processes.

4.3.8 Adaptation of the Role of the Ministry of Health

One of the key themes the researchers were asked by the funders of this research to focus on was Adaptation of Role of the Ministry of Health.

A strong majority of the Chairs interviewed reported a very positive relationship between their DHB and the Ministry, although several noted that their own primary relationship was with the Minister. The quality of the relationship with the Ministry was seen to be improving over time, with this attributed to high levels of mutual respect (*'we're no trouble to them, and they're no trouble to us'*), the hard work invested in maintaining the relationship, and the calibre of some senior executives in the Ministry (Gordon Davies, then Deputy Director-General, DHB Funding and Performance, received a number of 'bouquets'). A number of specific examples were given to illustrate the approach of the Ministry: *'they managed a difficult transition well'*; *'they managed the intensive monitoring situation well'*; *'they are very open and accessible now'*.

There were some areas where Chairs thought that the relationship could improve. There was still the view that DHBs are over-governed and over-monitored, and that the Ministry could require less detail: *'too much compliance before you can even start to get on with the job'*; *'cut down on detail'*. This was associated with the desire for more local autonomy. Chairs recognised that the DHBs are spending public money and need to be accountable for this, but desired more flexibility.

Comments from two Chairs characterise the way in which both positive and negative views are embodied in individual respondents:

'I think they [the Ministry] have managed the transition very well. And I think it's an evolving system and it's remarkable what's been achieved in the last four or five years. We have total respect for them. We get frustrated with them and they get frustrated with us, but overall we're very complementary....There is a tendency not to completely let go. If you're going to make an organisation [the DHB] accountable, then don't put in excessive checks and balances, because you just end us with excessive bureaucracy'. (C 11)

'I think we really have respect for each other's roles and positions. We make sure our board members know what the Ministry has to deal with at their end, because it's not all 'beer and skittles' for them. They have to deal with

Treasury, with the Ministers, with a whole heap of other agencies and I think that it's important that our board...understands the barriers they have there...but we still want more flexibility and we would like them to leave us to do more things'. (C 6)

CEOs were generally more positive about the Ministry in the second round of interviews than they were in the first round, reflecting the more extended period of development of working relationships. However, there were specific areas where CEOs thought that more changes should have occurred, including in relation to the balance of responsibilities between central government and DHBs.

Nineteen CEOs commented on their overall relationship with the Ministry of Health (see table below). Six reported unreservedly good relationships with the Ministry; nine reported improving relationships (with both positive and negative experiences); and four reported ongoing difficulties.

CEOs' views on DHB relationships with Ministry of Health

Quality of relationship between DHB and Ministry	Details of ways in which relationships were reported
Good experiences	Relationship good now there is a focus on appropriate roles Ministry always helpful Ministry positive and flexible Personal relationships cordial
Improving situations	Ministry personnel more stable More regular communication sought by DHB DHB and Ministry working together to improve relationships CEO working to be more conciliatory
Some ongoing issues in the Ministry	Further focus on policy work required Below top-tier still very 'siloes' Difficult to get a single view across directorates (6 respondents) Lack of knowledge prevents good engagement Rigid account manager (one respondent) Some issues handled at too low a level

Where improvements over time were noted, these were usually characterised by improved communication, but clearly some CEOs were concerned about a lack of co-ordination across parts of the Ministry.

In the second round of data collection, CEOs made a number of comments in relation to implementation of policy, often in relation to the role of the Ministry of Health. The paper on Financing, Purchasing and Contracting notes issues in relation to the process of devolution of DSS funding. As noted earlier, a few CEOs reiterated their concerns about the role of the Ministry in implementation of the PHCS, with specific issues including direct negotiations between the Ministry and providers that left DHBs *'out of the loop'*, cutting across their relationship with PHOs and thereby undermining their continuing role. It was also reported that the Ministry had unrealistic expectations of the capacity and capability of primary care to fulfil requirements within the time frames set out, thereby placing unreasonable burdens on primary care organisations.

Views on the DAP process in this round of interviews were far more positive than previously when there had been strong criticism of Ministry requirements. Ten CEOs now reported a much better process for 2004. Several CEOs pointed out that the Ministry's framework and timeline (although still tight) had become more manageable and that greater flexibility was now possible.

'We haven't stuck strictly to the Ministry's format. We negotiated it with them and they were happy for us to depart from the format, but keeping it within the spirit of what it should be.' (CEO 14)

Similar views on the role and adaptation of the Ministry of Health were expressed through the case study research.

In one case study DHB, relationships with the Ministry of Health were significant and informants gave varying accounts of them. Board members expressed more satisfaction with the Ministry relationship than did DHB staff, commenting, for example: *'The Ministry in general were extremely supportive'*; and: *'Sound working relationship'*, although the Board itself did not have as much to do with the Ministry as did the Executive. Two informants noted the Ministry's willingness to send staff on request to provide briefings and presentations for DSAC and CPHAC.

From the DHB staff point of view, however, the relationship for most was not so happy, and this was because of the overall functioning of the system, and the Ministry's overall approach. At the level of individual staff and sections of the

Ministry, however, DHB informants named a number of outstanding individuals who were excellent to work with. Informants did not necessarily blame the Ministry for some of the problems the DHB faced in the relationship. One said, in connection with the period of PHO development, for example, *‘to be fair to the Ministry... they’ve had an ongoing battle with IPAC and NZMA...and were trying to manage that’*.

Some tensions noted by staff early in the research period grew from chronic historical tensions, they said, and issues around capability. The Ministry had been geared up to monitor one HFA and had inadequate resources to work with 21 DHBs. The Ministry’s work was multiplied by 21 in dealing with different personalities and documentation. One informant also commented that the Māori and Pacific teams within the Ministry were *‘invisible’* to the DHB.

But the key source of tension was over roles: *‘There’s a tension, every day it’s a tension’*. The Ministry held the purse-strings, and required detailed accountability data from the DHB. One informant summed this up:

‘The idea that Boards are autonomous, that Boards have all the power required for full governance is not correct. I think the Board functions best when it sees itself as a fully-owned subsidiary’.

The Ministry of Health was characterised by several informants as overly involved in DHB operations; involving *‘almost week by week direction’*. The informant who stated: *‘The Minister and the Government’s role is policy.... It’s really important for the Minister and the Ministry to stick to their roles’*, conceded that this is unlikely to occur in a small country, where government had set *‘too many directions’*, and community expectations were very high. Other informants agreed that the roles needed to be more clearly understood. One said that the Ministry was:

‘far too operational, [had] its fingers in far too many pies, [was] slow to hand over responsibility...and resource’.

For one informant, the Ministry of Health gave *‘a mass of conflicting advice and requirements’* and had *‘almost a paternalistic attitude to DHBs’*.

Other informants in this district felt the Ministry or the National Health Committee could do more in the areas of information technology, information management and technology assessment, and simpler contracting. It was felt that some major national

decisions were needed, for example, in the tertiary services area. As one informant said there was a need for:

'a formal national strategy for tertiary services which indicates what hospitals will do what.... There has to be some overall vision about how equitable access can be achieved throughout the length of the country'.

In this case study DHB, it was also suggested that a programme of realistic priorities agreed between the Ministry and DHBs was needed. There were too many new Strategies coming out from the Ministry. A non-DHB provider also felt that the Ministry staff were skilled in the strategy and policy field and not in operations and contracting.

For one informant there was a general lack of trust in the system, going both ways between the Ministry and the DHBs. This was *'frustrating and demoralising'*, because generally, this informant felt that DHBs had the skills and competency to do the operational work. It was through the accountability framework that the Ministry was overly and inappropriately involved in the details of DHBs' operations. At the end of the period, an informant summed up the relation between the DHB and the Ministry:

'There's a certain amount of "them and us" and I don't know that you're ever going to get rid of that'.

The Ministry's timeframes and reporting requirements were considered unrealistic by several informants in this case study DHB. By the end of the period, the DHB was more questioning of the Ministry as to why certain monitoring data were required, and tried to focus of requirements that were meaningful for both sides. It appeared to some informants that the Ministry's monitoring requirements were increasing over time.

In terms of presenting the first DSP, one informant reported that the timetable for this was not met by any DHB. Given that the DAP became a performance document, and entailed buy-in from a range of stakeholders, time was needed to develop it. At the same time, the state of formal documents and agreements between the Ministry of Health and the DHB was reported as improving. The operational policy framework for 2003/04 was greatly improved on previous years in terms of its logic and clear connections to legislation, policy or directives. The flow of information from the

Ministry to the DHB was *'quite a drip feed'* at the beginning of the research period, with information not always coming in a timely way. On the other hand, the Ministry received detailed quarterly information from the DHBs which it did not always then disseminate back to the sector, for example, on accountabilities and the balanced score-card. Problems of untimely information decreased; later in the period an informant reported that the Ministry was providing more useful, timely data.

The relationship with the DHB Funding and Performance directorate of the Ministry was crucial for this case study DHB: the branch was the Ministry's filter and *'front'* and brought the aspirations of all of the Ministry's directorates to the DHB. This was a mixed bag of diverse messages, relating to 38 Strategies – not necessarily with costings attached. Each Ministry directorate had staff passionate about their area's aspirations, and DHB Funding and Performance had *'a role to play in...checks and balances within the Ministry'*. As another informant commented *'different parts of the Ministry give you very different messages'*. Some of the difficulties encountered also related to different personalities and working styles. By the end of the period, the increasing continuity of personnel in both the Ministry and the DHBs was, however, proving valuable.

The prime relationships with the Ministry were through one of the Ministry's Account Managers, each of whom liaised with several DHBs. This relationship was described as excellent by all the participants who discussed it. In some cases the people involved on each side had worked together previously. In this case study DHB, there were regular informal meetings with the Account Manager, *'and that's smoothed things out dramatically'*. This informant reported that several other DHBs also had this kind of relationship with Account Managers.

The Account Manager for this case study DHB was interviewed for the Health Reforms 2001 Research Project in 2003 and commented very favourably on the DHB's professionalism and willingness to look at and resolve any problems that came up. The Account Manager commented on the way the DHB's size (it is one of the larger DHBs) enabled it to *'drive better synergies and [have] better economies of scale than a lot of other DHBs'*. As noted, one of the keys to positive relationships

related to the continuity of individuals in the health system. *'It's quite an incestuous sector...the same thousand people circulate in various parts of the system...'*

One point all informants seemed to agree on in this case study DHB was that the relationship with the Ministry was getting better year by year. An example given was the opportunity planning staff from DHBs had through DHBNZ to comment on and critique a draft Crown Funding Agreement; this kind of opportunity had not occurred earlier and was welcomed. At the end of the period, though, informants felt that the role of the Ministry still needed to develop. One informant wanted more information from the Ministry about what was happening internally there, through, for example, a quarterly report on projects the Ministry was working on or planning.

In another case study DHB, there were mixed views on the relationships with the Ministry of Health. Some informants commented on positive relationships with the relevant officials in the Ministry, another made a sweeping statement complaining that the Ministry was *'patronising and arrogant'*. Another again considered the relationship with the Ministry had not changed much since the reforms, although the accountability frameworks were now being refined which was a welcome change.

There was general agreement that while funding and responsibilities were devolved, at the same time the Ministry became more rigid in its requirements. One stated *'the Ministry seems to be growing and finding more and more rules and standardisation at the same time that it's supposed to be individual regions making their own decisions'*. It was considered that the Ministry has become *'more intrusive'* since the DHBs were introduced.

Most informants in this case study who commented on the balance of decision-making between the Ministry and the DHB expressed a preference for the Ministry to give the DHB more autonomy and responsibility, and would prefer the Ministry to be less prescriptive and to allow for more flexibility. One observer commented they did not mind the Ministry being in a regulatory role as they represent the interests of the Minister and ensure core services are delivered. However, it was hoped that as the DHB builds relationships and networks with the Ministry, their confidence in the DHB would grow which will encourage them *'to leave us to do more things'*.

Some specific criticisms were made by respondents:

- The Ministry's demands for reports being on time when the Ministry itself did not provide timely responses to the DHB;
- The Ministry's lack of practical knowledge of the issues that the DHB faces or might have to face: *'I think there's a tremendous amount of ill-informed comment coming out of the Ministry'*;
- The amount of information the Ministry demanded which requires *'this enormous clerical infrastructure in a hospital. We get nothing back from the information but they keep demanding it'*;
- Poor communication, for example Ministry visitors not giving adequate forewarning.

Some factors were seen to have improved or facilitated better relationships:

- Additional funding with an associated change in the DHB's monitoring status;
- Some improvements in the processes around the DAP;
- The networking occurring on national and regional committees which allows the building of informal relationships between DHB and Ministry personnel;
- Previous knowledge of one another as individuals move around within the health sector;
- Communication protocols, which identify who should be contacted for what purpose. Conversely, when these are not followed, for example, Ministry officials writing directly to chairs, it both slows down processes and creates confusion, as the chairs believe they should respond directly. In addition, if information is sent directly to them, it bypasses the DHB management;
- Regular meetings between the Ministry and key DHB personnel.

Regular meetings are held between this DHB and the Ministry of Health every six months. This was seen to provide an opportunity for participants to review matters of mutual interest, but in particular the statutory committee chairs shape the agenda to raise emerging issues. This meeting was considered to have led to the development of *'real respect'* for each other's roles and deepened understanding of key issues.

In this case study DHB, the Ministry of Health had also been readily available for advice and support regarding the implementation of the PHCS which had been appreciated. However, one informant suggested that the Ministry has not always had a handle on the practicalities of implementation, nor have they been able to share information about how others have solved particular issues.

Informants in this DHB noted various changes they would like to see:

- The refining of the accountability frameworks needs to be speeded up;
- Speed up the Ministry's decision-making and responsiveness;
- Less control from the centre.

The appropriate role for the Ministry was seen as maintaining an overview, monitoring developments and undertaking analysis of the sector.

In another case study DHB, a number of similar comments were made. Here, it was recognised that the operational policy framework sets out the formal agreement between the Ministry and the DHB, but also that *'at the end of the day though it is how people work together – that's our main issue rather than what is written on paper'*. Although some informants regarded the relationships with individuals and the Account Manager as very good, others saw the relationship with the Ministry as problematic. Some examples of the issues raised in this DHB are given below.

One issue raised related to consultation. In this case study DHB, the consultation conducted by the Ministry on the strategies was regarded as rubber-stamping rather than a genuine exercise in consulting. *'Sometimes you know they've made up their mind anyway - you feel as though they are doing it because they have to but they are not going to listen'*. And from another *'I went to every meeting – we didn't make a blind bit of difference I don't think'*.

Another issue related to planning processes. Although the planning documents and HNA were sent to the Ministry for sign-off and comment, it was reported by one informant that *'no real assistance'* was given by the Ministry on the process. The timeframes for doing tasks was perceived as not realistic, but then there were also no

perceived penalties for not meeting deadlines. A complaint was made that the turnaround on documents was sometimes very slow, citing the example of a survey sent in for comment, which was only returned a whole year later, by then no longer relevant. In another case, it was noted that the Ministry had not responded to a letter relating to a Māori Health Plan.

In another case, it was felt that responsibility for ensuring safe mental health services was pushed onto the DHBs, with one informant in this case study DHB believing that the Ministry of Health could and should have played a more helpful supportive role to support the DHBs with the media, and that they had a crucial role in working with the DHBs' provider arms to address capacity issues. There was comment from another informant that the current structure is more about shifting blame, whereas others expressed understanding of the Government's desire to keep a national lead on health for consistency.

Not all informants found the relationship with the Ministry problematic. In particular, Māori provider informants in this case study district consistently reported positive experiences relating to the Ministry. One Māori provider informant said the relationship had been good, helped by a lot of continuity of relating to some of the same people over an extended period of time, predating the reforms. This informant valued the relationships which were maintained by making efforts to keep in contact by calling in at the Ministry when down in Wellington, and by using *whānau* contacts who were employees of the Ministry. In turn this provider organisation informant said they demonstrated their loyalty to Government by, for example, being openly supportive of the PHCS. At the second round of interviews, one informant pointed out that the Ministry *'didn't have a vested interest as local decision-makers have with funding decisions. Locally everyone has their own agenda, which goes beyond "conflict of interest". You can't be part of a community without vested interests, from the waka to the stroke association'*.

Informants in this DHB reported that some efforts have been made to streamline the interface between the Ministry and DHB. Every Monday morning *'a big package'* arrives from the Ministry with the communications for the week. *'It used to come in bits and pieces but now we get it all at once...It's a huge amount of stuff and is*

literally impossible to take cognisance of all of it'. This informant also observed that the same package was delivered to large and small Boards, but as a small Board they had less capacity to deal with it.

Informants in this case study district similarly made suggestions about how the relationship with the Ministry of Health could be improved:

- Having clearly defined roles and boundaries for the Ministry and DHB respectively then to let the DHB get on with it.
- For the Ministry to devolve to the DHB to allow local decision-making.
- For the Ministry to let go more and 'to have less of it,' just being there to answer questions.
- Another informant could see improvement in the relationship if there was a relationship manager rather than separate representatives of personal health, primary health, mental health, and disability support services. The experience was that these different service representatives did not communicate with each other. This was contrasted with previous systems when there was a single person looking after the whole region, which promoted greater coordination.
- It was suggested the Account Manager and other Ministry staff should come out to the DHB sometimes.

At least one informant thought the relationship was improving overall with the Ministry '*keeping out of our hair a lot more*', as the DHB asserted its independence increasingly. The efforts the Ministry has made to improve relations with the DHBs were acknowledged and it was recognised the changes impact on the Ministry as well as DHBs. The devolution of services meant roles were changing or lost, and the uncertainty about devolution imposed as much uncertainty on the Ministry staff as the DHBs.

Those interviewed in professional organisations also had some comments about the role of the Ministry of Health. For example, one informant felt that the major weakness of the strategies was seen to be their implementation processes. The Ministry of Health has made decisions about the '*very high level policy*' but was perceived to not consider it their role to make operational policy. However, in the

absence of there being any other national body with responsibility to lead implementation, this was seen to be a ‘vacuum’.

One respondent spoke positively of the dramatic transformation of DHBs over the period of the reforms, but went on to say, *‘I don’t think the Ministry has [transformed] to the same extent ... it seems more like an adaptation than the sort of transformation of DHBs’*.

Another respondent believed *‘there needs to be right throughout the system more trust’*. They considered the Ministry was still operating under a *‘legalist, distrustful approach’* of previous models. Whereas the Ministry was perceived to have got *‘bigger and bigger to try and keep control of everything’* it was suggested the Ministry needed to trust the DHBs with the authority and to take out a lot of the monitoring. *‘It doesn’t need to be there ... excessive monitoring damages trust’*. According to this informant the Ministry should have a role in pulling together high level strategy, looking at the broad health objectives and then monitoring and reporting on these with regard to all policy areas for their impact on health. This was seen as analogous to the role adopted by Treasury.

A third respondent questioned whether the Ministry should adopt a *‘hands-on’* or *‘hands-off’* approach to implementing policy. With regard to the Primary Health Care Strategy:

‘I think the Ministry would say that they have constructed a policy framework around which there are some givens but within which there is room for considerable leeway and local interpretation ... [but] I think they’ve allowed a great deal of ‘business as usual’ to go on ... We need evolution and partly I accept that. But actually there’s a small amount of revolution needed to allow the evolution to occur. There needs to be a revolution around the funding streams to allow the evolutionary changes of behaviour that will result. Whilst the funding streams remain as they are, then no evolution can occur because nurses particularly can’t get to do things differently.’

With regard to PHOs, general practitioners were perceived to have dominated the direction of PHO development and implementation frustrating Māori and consumer representatives. Although there was observed to be a sense of lip-service in most places, *‘I do know of some really impressive models of partnership and innovation and development’*.

The Primary Health Care Strategy in particular elicited considerable comment. One informant stated:

‘I think the implementation of the Primary Health Care Strategy has still got a lot of work to be done there. And given that it is so central I think it’s a major risk really to achievement of the overall strategies.’

Another respondent said:

‘The implementation phase of primary health organisations has been abysmal. There has been no implementation plan. There’s been no risk management, there’s no risk analysis. It’s been rushed. It has ended up with all sorts of problems because of that.’

One respondent commented on the Māori Health Strategy, which was considered a very good strategy. However there was again concern about weakness in its implementation, with the Ministry taking a ‘hands off’ approach. It was also felt that not enough work was being done on capacity building to ensure the success of the plan.

The need for workforce development was also mentioned in regard to the other Strategies which:

‘to a large extent depend on an available, prepared, well-disbursed workforce ... yet workforce is one of the areas which I think has rather dangerously fallen between DHBNZ, the Ministry and everybody else’.

A disability sector informant identified the home support services as *‘an area where there’s very low pay, there is very, very high turnover and there’s a lack of training and there’s no change to that. That’s not something that I think can be implemented from DHB to DHB, that’s something that needs national coordination.’*

4.3.9 Other Issues

One NGO considered a negative impact of the health reforms was the duplication of compliance:

‘The DHBs have picked up compliance, but the Ministry kept it as well. So we have literally had some of our services audited three times within the space of three months, twice by the Ministry and once by the DHB ... And these are not issue based. These are not because there’s been a concern, it’s just routine audits ... And it’s actually quite ridiculous’.

Furthermore, the DHB was unaware that the Ministry was also conducting an audit, and:

‘we had two parts of the Ministry of Health come in and audit within two weeks of each other and they didn’t know the other part had come ... So different parts of the health system aren’t talking to one another’.

On top of this auditing process, this organisation also was addressing the requirements for certification under the Health and Disability Act, which may add further duplicate assessments of a service. The provider was concerned about the heavy cost of compliance to meet *all* these demands, and the resources that were being taken away from services. They also considered there needed to be trust between each of the auditing agencies.

In one case study DHB, comments were made about other services where funding remains the Ministry of Health. Midwives and dentists are still managed by the Ministry. Dentists view public funding *‘with some cynicism,’* as it only makes up 20% of their income *‘so they don’t want to be part of a three ring circus where they have to adapt some of their behaviour and culture when it only contributes a small part of their income’.* Therefore informants in this DHB were not agitating for devolution of funds for dentistry.

4.4 Responsibility for Decision-Making

In 2004, a new set of questions was asked in the DHB Board member survey about where major decision-making responsibility currently lies and where it should lie. The survey covered a range of issues (eg, deciding on the range of services to be covered, appointing members to the DHB Board). The respondents were asked to choose between decision-making:

- At the district level (DHB level)
- At the regional level
- With the Ministry of Health, and/or whether
- DHBs and the Ministry should share the decision-making.

The questions drew some comment in that they could have asked about the role of the Minister as opposed to that of the Ministry of Health; however, in our interviews and in free text responses to the questionnaires, many refer to the Ministry of Health as a ‘catch-all’ covering both the Ministry of Health and the Minister of Health. We feel confident that respondents understood that the focus was on central vs local decision making.

Descriptive statistics are used to report on the percentage of respondents stating where current decisions lie, followed by where they should lie. Following on from this, a Kappa coefficient is used to measure agreement; that is, over the entire group of respondents, the concordance between an individual’s response to a question about where responsibility currently lies and an individual’s response to a question about where responsibility ought to lie. The closer the value of the Kappa coefficient to 1, the better the agreement. Kappa measures less than zero indicate no agreement; from 0.0-0.19 indicate poor agreement; 0.20-0.39 indicate fair agreement; 0.40-0.59 indicate moderate agreement; 0.60-0.79 indicate substantial agreement and 0.80-1.00 indicate almost perfect agreement.

Respondents saw the following as current DHB functions:

- decision-making in relation to the Treaty of Waitangi (45%; the remainder of the respondents were split between this being a Ministry (26%) or being a shared function (25%)).
- consulting with the public on priorities (77%)
- setting salaries for staff within the DHB (40%; with 29% seeing this as a shared function)
- selecting providers to contract with (79%)
- determining the price to pay providers (40%; with 31% seeing this as currently a shared function)
- monitoring provider organisations (73%)
- determining PHO approval/selection (59%; with 25% seeing this as a shared function).

Respondents saw the following as current Ministry of Health functions:

- determining public health issues to address (53%; with 29% seeing this as a shared function currently)
- appointing members to the DHB Board (72%)
- selecting the Board chair (81%)
- negotiating user charges in primary care (54%, with 23% seeing this as a shared function).

Respondents saw the following as currently shared functions between the Ministry of Health and DHBs:

- determining priorities over the next 1-5 years (45%; while 33% saw this as a current DHB function)
- determining priorities over the next 12 months (50%; while 34% saw this as a current DHB function)

Responses had differing views in relation to:

- deciding which New Zealand Health Strategy objectives to concentrate on (36% DHB function, 33% Ministry function and 28% shared function)
- deciding how much funding to put into different programmes (36% shared function; 34% Ministry of Health function; 26% DHB function)
- decisions on the range of services to be covered (40% Ministry of Health; 38% shared)
- decisions on reconfiguring services (37% DHB function; 34% shared)
- determining the volume of services to be purchased (37% DHB function; 36% Ministry of Health function; 34% shared function)
- deciding what advisory committees the Board adopts (39% Ministry of Health; 37% DHB function; 24% shared)
- allocation of decision-making for assessing the performance of the DHB service provider arm (36% shared; 34% Ministry of Health; 26% DHB function).

Many of these findings align with the research team's understanding of the current allocation of responsibilities between the Ministry of Health and DHBs; where key governance roles are undertaken by the Ministry of Health and public health funding lies with the Ministry, albeit in a shared decision-making framework; and where DHBs have responsibility for many provider-level decisions. In terms of priority-setting responsibilities, DHB Board member views on where responsibility for this lay were split, reflecting perhaps the shared roles the agencies play for example in determining services to be covered and the allocation of resources through annual planning rounds.

The comparisons between the questions asking about where decision-making currently lies and where it should lie showed a desire by DHB Board members for more decision-making responsibility; and the Kappa statistic supported these findings, showing at best only fair agreement. In particular, there was poor agreement – suggesting a larger gap between current and desired role allocations – in relation to:

- deciding which New Zealand health strategy objectives to concentrate on
- determining public health issues to address
- appointing members to the DHB Board
- selecting the Board chair

- deciding which advisory committees the Board adopts
- selecting providers to contract with
- negotiating user charges in primary care.

5 How Can the Model Be Improved?

In our interviews, we asked key informants about ways in which the NZPHDA model might be improved. Many informants stated a strong desire for the reforms to be given time to bed down, and that they did not wish to see further major structural change introduced. In this context, this section of the report notes the major improvements that informants suggested with respect to devolution, and how these suggested improvements would impact on the sector.

In relation to devolution of funding for disability support services – Informants pointed to a number of benefits they expected from the devolution of funding to DHBs for DSS for those aged 65 and over. These included more effective monitoring at a local level (given a feeling that many contracts had not been properly monitored prior to devolution), the ability to work flexibly and innovatively with local providers, and the ability to find efficiencies and to consider service improvements across the entire aged care sector. In one case study DHB, it was felt that devolution would increase transparency for the community, who could see where the money was going and be able to judge whether this fitted with their awareness of their needs.

Although some informants wished to see funding for DSS for those aged under 65 devolved to DHBs, most informants did not suggest this change should occur. Informants in one case study DHB who wished to see further devolution pointed to potential benefits in further integrating services with chronic care services and could see benefits in developing closer linkages between providers and DHB staff. Others, however, felt that the Ministry of Health knew the services, were concerned about the funding for DSS being eroded if DHBs were responsible for decision-making, and were worried about the risk to national consistency if DHBs were left to make their own decisions on services. If funds were to be devolved, informants wanted safeguards around the funds (eg, Ringfencing) and adequate resourcing for DHBs.

In relation to devolution of funding for public health services – The majority of those interviewed expressed a preference for the devolution of funds for public health to proceed. This would promote a population health focus, ensure local priorities could be progressed, enable services to be developed in ways which best meet the needs of local populations, enable the exploration of economies of scale across public and personal health services, and encourage integration with developments in primary care. Some informants felt that at the very least there needed to be closer alignment between local and national priorities, with some noting that local work with PHOs and in priority areas such as diabetes could be strengthened with access to public health funds. Some informants also acknowledged that there were essential national public health roles, and that there were definite efficiencies that could be achieved through regional collaboration. Ring-fencing was suggested as one way of ensuring merged funding streams were kept for the purpose intended.

Amongst Ministers and officials there was a view that the more important question was how we should be ‘doing’ public health. One key informant suggested there was a desire to see national standards set in place first before public health funding is devolved to DHBs. Engagement of the community around public health objectives was another issue raised, with one suggestion being to hold a regular public health care forum to stimulate public debate and local interest in key issues.

A minority of research respondents were happy for the status quo to continue. The reasons given for this included that it was preferable for the DHBs to consolidate their roles before taking on this added responsibility; the need for national consistency across services such as screening programmes; and the need to retain a critical mass of public health expertise in a single organisational setting. Furthermore, some of those interviewed considered that some public health contracts should remain national contracts, even if the majority of public health contracts were devolved.

In relation to the role of government strategies – Both case study and national stakeholder informants suggested that the number of health strategies should be reduced. Furthermore, strategies should be integrated and consistent with one another. A number of informants across the research commented that having fewer strategies would result in the ability to focus and to consolidate progress in a few key areas at a

time, and then move onto other areas over time. There was an indication in the research that work on a number of strategies at a national level could easily be wasted if local organisations did not have the resources to progress the strategies. Informants also suggested that they would have their own local priorities – which differed at times from national priorities – to implement if there were fewer government strategies.

In relation to the role of central government in planning and funding decisions –

Across the research, a key recommendation for improvement was the reduction of central decision-making and constraints and an increase in local autonomy. Of particular concern to DHBs was the ability for central government to dictate what had to be done and for DHBs to then have to find the funding to cover the associated costs. Some informants also noted that there would be little point in having the whole DHB infrastructure, including community involvement and local strategic planning, if decisions at a local level were significantly constrained.

Informants suggested that a reduction in the role of the centre would be likely to lead to improvements in health and disability outcomes, as a result of:

- more innovation and the better tailoring of solutions to local needs (as a result of DHBs working closely with their communities and having greater knowledge of local issues)
- more timely decision-making, and
- improved ownership of issues at a local level (thereby improving implementation).

There was also a view that a greater degree of flexibility at local level would enable DHBs to spend resources in ways which better meet local, as opposed to national, priorities.

In relation to the number of DHBs – Many respondents across Chair, CEO and case study research streams commented that there are too many DHBs but they stopped short from recommending amalgamations. Local input was highly valued, giving greater confidence in the prioritisation that goes on locally. The focus of development has therefore been on how to retain the local governance structure while also managing

and mitigating the problems arising and the costs incurred through there being 21 DHBs. In practice, this has meant identifying which aspects of local decision-making are valued and where cost savings, economies of scale and sharing of clinical resources could enhance the current system. Across the research, amalgamations were not perceived to be appropriate because of the variability of communities of interest between districts. The district-based decision-making model was seen to more easily accommodate this variability and there were perceived benefits from local needs assessment and planning processes.

Many informants saw DHBs working closely together as the way forward, particularly to achieve accessible and sustainable services. Some informants felt that if the sector were restructured, the focus would turn to structures rather than doing things better. Instead a lot could be achieved through collaboration and regionalisation, and maintaining identities. They pointed to international evidence which suggests the benefits of mergers are rarely those that are promised. In addition, it was noted that when restructuring occurs, people focus on the politics rather than what the health system is all about. The development of regionalisation of services – in mental health, public health, surgical services and cancer – were all examples of where the sharing of services has evolved over time.

The national stakeholders we interviewed also shared the view there were too many DHBs. They were more consistently in favour of amalgamations because of the greater costs they incur through relating to multiple DHBs and because of concerns about the potential loss of national consistency from having 21 DHBs. One professional organisation respondent considered 21 DHBs is a duplication of activities in a way that is wasteful both in terms of finances and also in terms of expertise that the country needs. Centralising organisation was perceived as more sensible and more conducive to national consistency. However, another respondent did not believe reducing the number of DHBs would make much difference for the better or save money, as site management would still be required even if a number of DHBs were consolidated. *‘What is more important is the actual clinical and collaborative alliances.... The money will be saved in having more effective clinical coordination and integration, with better IT systems across the board.’*

Suggestions for improvement included retaining local decision-making and purchasing while reducing the number of provider arms. Several CEOs suggested a dual system whereby small boards undertake planning and funding roles, but with larger boards supplying hospital services. Any amalgamation of functions from smaller DHBs could be protected by ring-fencing resources and services for that district. Opinions varied as to whether existing governance structures should be retained in such an arrangement or whether the Board could be dispensed with in favour of a General Manager and management structure.

In relation to collaboration – All the research streams reported a call for greater collaboration and integration throughout the health sector. This was seen as applying to the integration of services within DHB areas; active DHB-DHB collaboration; integration of strategic planning between DHBs and local government; and clear alignment at every level between the Ministry, the DHBs, and the non-Government sector to work on agreed strategies to achieve some real culture change.

Both case study and national stakeholder informants advocated the national health strategies should be more integrated to provide the national leadership towards service integration. Some CEOs commented on the need for attention to co-ordinate policy across Ministry of Health directorates, especially given the large number of strategies.

Some national stakeholders saw DHBNZ as potentially offering a national focus for a range of tasks, including enabling further development of regional level discussions. One NGO representative would like to see DHBNZ strengthened, and become the agency for managing national contracts *‘so I have one person to go to and discuss every issue that I needed to discuss’*, rather than having to deal with a number of Boards individually. Some case study informants saw DHBNZ as potentially taking a greater role in some of the DHB’s operational functions as a means of reducing costs and overcoming capacity constraints in DHBs. A minority viewpoint was that there should be consumer and family representation on DHBNZ.

However, while CEOs strongly endorsed DHBNZ’s value, they reiterated this organisation is *‘a servant of the DHBs’* and not a national body representing DHBs’ views, the role often ascribed to DHBNZ by others in the sector.

In relation to capacity and capability – A number of recommendations were made in relation to improving capacity and capability, including that the Ministry of Health had a need for more senior analytical skills, and that the sector has a need for increased training, capability and capacity in relation to planning, purchasing/contracting and monitoring skills, as well as in relation to leadership skills. A number of informants suggested a need for improved knowledge and understanding of primary health and disability support services within DHBs, while others also noted key areas of clinical workforce shortages which urgently need addressing. Some informants however felt that some policy and planning may be doubled up in some of the DHBs, and they noted the importance of clarifying roles in order to avoid duplication. Some informants also pointed to the need for more collaboration, not only between DHBs, but also across government agencies doing similar work, in order to remove duplication. Secondments between DHBs and the Ministry of Health were also mentioned as a way of sharing expertise and transferring skills. Regionalisation of some more specialised tasks and services was also suggested as a way of improving the model, to overcome perceived fragmentation of scarce skills and limited capacity, now spread between 21 DHBs. This was already occurring in relation to some mental health services, and some DHBs were noted to be working collaboratively on some operational tasks.

In relation to the adaptation of the role of the Ministry of Health – Informants made a number of suggestions in relation to the role of the Ministry of Health:

- clarification of the role of the Ministry, more autonomy to the DHBs, and a preference for the Ministry to only focus on strategic policy
- recognition that the demands of the Ministry of Health often outstrip the capacity of the sector, particularly of smaller DHBs, to respond. It was suggested that there needs to be a more focused monitoring regime and more local autonomy in decision-making
- recognition that reporting requirements were seen to be onerous. Suggestions for improvement here included reporting more on outcomes and measurements that are meaningful to the DHBs, in order to get away from overly prescriptive and onerous reporting which has little relevance to the DHB

- increased trust throughout the system, including increased trust by the Ministry of Health in other participants in the sector, in particular in DHBs
- increased co-operation and responsiveness from the Ministry of Health
- improved co-ordination within the Ministry of Health, including across directorates and in relation to strategies.

Informants suggested that if there were increased autonomy for DHBs, the benefits would include a reduction in bureaucracy, which would result from their being fewer ‘*excessive*’ checks and balances, and improvements in DHBs’ ability to rationalise services and meet local needs. A few CEOs also noted that direct negotiations between the Ministry of Health and providers could cause difficulties at a local level, and undermine the role of DHBs. CEOs pointed, for example, to unrealistic expectations of capacity and capability of primary health care to fulfil Ministry of Health requirements within time frames, thereby placing unreasonable burdens on PHOs. Some informants felt that smaller DHBs might particularly benefit from a reduction in the work undertaken in relation to monitoring. It was also clear from the interviews that many felt that a reduced role for the Ministry of Health would lead to increased flexibility and innovation at a local level. There was also a suggestion that increased autonomy would enhance accountability, by giving DHBs the responsibility for making changes.

Many informants in DHBs wished to see a streamlining in performance management processes, implying that this would lead to reduced workloads at the DHB, and the freeing up management time and attention which could then be spent on developing or improving services. This is not to suggest that DHBs believe there should be no monitoring requirements. A number of informants suggested the development of more meaningful indicators, along with feedback to DHBs on performance. Some informants in DHBs noted that some measures are helpful for DHBs as well, as a starting point for DHBs’ own monitoring. Others suggested that there could be more on-site observation and a genuine attempt to capture health outcomes.

6 Discussion

This research has shown that devolution has emerged as a key issue in relation to the NZPDA model and its implementation. The key issues that the research raises are set out below.

Devolution of Funding

The original intent of these reforms was for funding for most services to be devolved to DHBs, as DHBs showed themselves capable of managing these responsibilities. Some specific exceptions to devolution were identified early on by Cabinet – including some tertiary and quaternary hospital services, some disability support services, and some public health programmes and services delivered by national organisations. The reforms have resulted in the devolution of much health and DSS funding to DHBs, including for medical and surgical services, mental health services, and DSS for those aged 65 years and over. DHBs are now responsible for planning services, and for purchasing or providing these services at a local level.

Funding for DSS for those people with disabilities who are aged less than 65 years of age, and for public health services, remains with the Ministry of Health. This research has found a mix of views on the desirability of devolving responsibility for these services to DHBs – in general, DHB informants preferred to have the funds devolved while other groups had mixed views as to the desirability of further devolution.

The current model appears to have the potential to lead to a number of problems, including: disagreements about whether the Ministry of Health or DHBs fund particular services and people; cost-shifting between services; the creation of a complex contracting environment for organisations which work with both age groups; and inconsistencies in funding and in service delivery at a local level between the two funding models, potentially resulting in problems when people turn 65. On the other hand, there is concern that the health sector is not philosophically attuned to working with the needs of younger people with disabilities, as well as concerns over the impact

on national consistency (see below) and on the impact of devolution on those organisations which would then need to work with 21 DHBs in organising services.

With devolution of funding for those aged 65 and over having occurred only in the past two-to-three years, it is too early to identify how these issues will impact on service delivery and client outcomes. Further information about the performance of DHBs in DSS, and about the impact of the split in funding on service providers and on those receiving services as they turn 65, would seem to be appropriate in these circumstances. In the meantime, the Ministry of Health itself needs to be held accountable for its decision-making, contracting and monitoring of DSS for those aged under 65 years of age, while the Ministry of Health and DHBs need to work together to iron out any problems, particularly where these directly affect service delivery to individuals.

In terms of public health services, there are again different views on the desirability of allocating public health funding to DHBs. Those working in DHBs generally are more supportive of devolution, while other informants have mixed views on the desirability of devolution. Many services are organised at a regional level already, through regional public health services, partly in order to retain a critical mass of expertise. Other contracts are for relatively small amounts of funding, allocated to a single national provider, where the splitting funding to 21 DHBs would increase transaction costs and result in even smaller amounts of funding being available at a local level. Devolution of this latter funding does not appear to be a sensible move, and continued joint decision-making between the Ministry of Health and DHBs will assist in aiming to ensure the services so purchased are of high priority.

However, the research suggests that retaining this funding centrally does not support the message that DHBs have a key role to play in relation to population health, health promotion and disease prevention. One way to manage this situation is to allocate DHBs specific funding for population health approaches, for use at a local level. Over time DHBs which are focusing on population health will inevitably put their own resources into this area, potentially leading to less emphasis on the national contracts and leading to duplication of services across the country. This tendency will be exacerbated by the allocation of population health funding to PHOs in implementing

the PHCS. Health promotion funding has already been allocated to PHOs in this way and as PHOs develop population health approaches further in the future, it is likely that public health funding at a local level will increasingly become more important relative to national programmes.

Devolution of Decision-Making to DHBs

Once funding is devolved to DHBs, we might expect that devolution of decision-making would automatically follow. However, as has been noted in the international literature on this topic, a key research question is whether devolution in decision-making does in fact occur.

An important initial question here is, what were the New Zealand Government's original intentions in relation to devolution of decision-making under the NZPHDA model? Our research suggests that there would eventually be a high degree of DHB autonomy within the NZPHDA model. Various documents note, for example, the importance of DHBs having '*flexibility*' to provide or fund services, '*deciding on the mix, level and quality of... services*' and evolving '*towards maximum autonomy*'. The ability for DHBs to determine their own priorities would also seem to reflect the overarching goals the Government set for the sector – restoring community involvement and ownership of health at a local level and '*empowering communities*'. However, there are also statements and comments that DHBs were also to work within national strategies, and within nationwide service coverage and quality standards.

Throughout the research we have found a lack of clarity as to how these two conflicting approaches would, in practice, balance out. The research has shown that many informants believe that DHBs have insufficient autonomy and that there is a desire for greater devolution of decision-making to DHBs, along with less direct involvement of the Ministry of Health in planning, decision-making, and monitoring. This view was found amongst many informants, working in different parts of the sector. Thus, the research suggests that for many in the sector, the balance has tipped towards a higher degree of central control than is desired at a local level. Not all the participants in this research supported this view, however. Some participants working

at a central level have a view that DHBs have a lot they can decide upon, but that in order to promote national consistency and ensure accountability for central government funding, a degree of centralised decision-making is no bad thing. In this research, these opposing views appear to have hardened over time, with the concerns raised by DHBs and at a local level about lack of autonomy increasing during the research, while key informants including Ministers and officials suggest that those working at a local level had to get on with their role, and to understand the important decision-making role of central government.

The research does not inform us in detail as to exactly why the NZPHDA model has developed in the way that it has. Within the New Zealand health sector, there has been an increasing degree of centralisation over time, with central government policy promoting amalgamations over time, a tightening of financial arrangements and increased oversight of financial outcomes, and increased requirements from central government. Under the 'quasi'-market model there was also a trend towards a tightening up of requirements on RHAs and the HFA over time, as central government sought to push the sector to achieve key government goals, and to manage problems (Cumming and Scott 1998). In spite of the establishment of what looks to be a more local model, it may be that those working in the NZPHDA model found it harder, in practice, to move away from the centralising trends of the past few decades.

Some informants in this research suggested other possible reasons that may explain the findings here of less devolution than may have originally been envisaged. Some informants suggested that the degree to which New Zealanders look to central government to fix problems in the health sector is one reason why central direction tends to occur. Other informants suggested that perhaps the size of the Ministry of Health itself would lead to work being generated by the Ministry of Health and hence to higher degrees of central control than might be desirable. In addition, Ministers and Ministry officials have pointed to a strong desire for New Zealanders to have consistency in access to services as a key reason why a degree of central direction may be necessary. Each of these factors may have played a role in terms of less devolution and might otherwise have been anticipated.

Our findings on this issue very much mirror findings in the international literature in relation to how the process of decentralisation works in practice. The international literature points to the complexities involved in implementing decentralisation, and the opposing forces which can operate to reduce decentralisation in practice. These arise in part due to sensitivities over control and direction of the system and possibly as a result of central government agencies traditionally being held to account for decision-making in the health sector by citizens at regional or central levels (Mills 1990; Lewis and Kouri 2004). Allen (Allen 2006), for example, notes contradictions in NHS policy that are similar to those seen in New Zealand, with policies promoting both centralisation and devolution often being introduced at the same time. Allen concludes her review of recent NHS policies by noting that it is not always clear what it is that the English government is trying to achieve. She also suggests that decentralisation has also been seen as a means of decentralising blame when things go wrong, and that, if this were a key goal of the English government with respect to the NHS, then recent events show that central government is still often held to account for problems which arise in English health care.

Conflicting Goals

In reflecting on devolution within the NZPHDA model, those interviewed for this research have identified the influence of the same issues found in the international literature on devolution. That is, they point to a tension between, on the one hand, achieving equity of access goals across the country, obtaining economies of scale from having larger rather than smaller organisations, and ensuring capacity and capability to undertake key tasks; and on the other hand, promoting local responsiveness and technical efficiency.

Saltman, Bankauskaite and Vrangboek (Saltman, Bankauskaite et al. 2007) note a recent trend amongst a small but growing number of countries to retreat from key aspects of devolution, with some countries establishing fewer, and larger, regional agencies to manage health services. They ask whether issues relating to new technologies, administrative efficiencies, and concerns over equity across regions are leading to policies to regionalise policy and management functions. They conclude that the key issue for policy-makers is to find a balance between centralisation and decentralisation forces that ‘fits their national values and context’ (p.4) with the need

to regularly revisit and adjust the balance. Peckham *et al* similarly stress that devolution is not an end in itself, and suggest that there is a need to give more explicit recognition to the trade-offs that exist between different policy goals (such as equity, efficiency and responsiveness) (Peckham, Exworthy et al. 2005).

In this vein, in moving the NZPHDA model forward, New Zealand policy makers firstly need to decide on the degree of devolution that is appropriate for New Zealand. This needs to be done by considering which of a number of key goals New Zealand is trying to achieve, first and foremost, for its health and disability sector. A focus on local responsiveness supports a stronger degree of local decision-making, while a focus on equity across regions, and a strong desire for central government accountability, may require a high degree of central decision-making.

As part of this, we should consider what the international literature tells us about whether devolved or centralised systems do generally achieve their respective goals. The international literature reviews referred to here find that the evidence in relation to the impact of devolution on key policy goals is limited, often weak, and equivocal in many cases. There is, however, some support for devolved models focusing on local needs and for promoting responsiveness and allocative efficiency goals. Our research has found that many in the sector agree with the potential in this area – in particular, a number of participants in this research felt that local decision-making is helped along by closer working relationships at a local level, and that services can be better tailored at a local level to meet local needs as a result of devolved decision-making.

Although there does appear to be potential in achieving these key goals through increased devolution, the international literature also points to possible concerns over devolved models of decision-making. Of particular relevance in New Zealand are, possible concerns at a local level in terms of how majority groups may come to dominate decision-making, making it difficult for those from smaller groups to have their voice heard. People working in ‘cinderella’ services perhaps reflect this when they raise concerns about the possible effects of devolution of spending decisions to DHBs, with DSS, public health, mental health and primary care groups weary, to some degree, of dominance by hospital services. In this research, Māori and Pacific

participants in this research have also noted a number of problems working at a local (DHB) level in terms of lack of representation at times on DHB Boards, and lack of attention to Māori and Pacific health issues. The literature does not readily identify ways of better managing these issues, but the use of ring-fenced budgets and strong performance management processes should be investigated further in the NZPHDA context.

The international evidence also suggests there are on-going concerns that devolved decision-making may lead to increasing inequities across regions, but there is a lack of evidence as to whether inequities increase across regions or whether improvements in equity occur within regions as a result of devolution. Disparities in health and in access to health services are well known in New Zealand (Ministry of Health 2000; Ajwani, Blakely et al. 2003; Ministry of Health 2004; Ministry of Health and Ministry of Pacific Island Affairs 2004; Ministry of Health 2006). In this research, we were not able to undertake the type of analyses which might provide us with an indication of how the NZPHDA model was impacting on disparities in health, given that there are likely to be long lead times in changes in organisation and service delivery and the difficulties of linking changes in the organisation of health care systems with changes in health status. An overview of published New Zealand reports shows mixed achievements in relation to equity of access to services (Mays and Cumming, 2007), but it is not possible to determine how devolved or centralised decision-making has impacted on this, given the mix of arrangements present in the NZPHDA model. It is worth noting that Peckham *et al* query the extent to which equity can actually be achieved across regions, and New Zealand's experience with elective surgery prioritisation and booking systems shows the difficulties in achieving the degree of equity that might be sought under a devolved model (McLeod, Cumming et al. 2002; McLeod, White et al. 2002; McLeod, Dew et al. 2004; McLeod, Morgan et al. 2004; Dew, Cumming et al. 2005). A fair allocation of resources to districts with likely higher needs will be a first necessary step in promoting equity (Koivusalo, Wyss et al. 2007). Some regulatory measures (for example, enhanced performance management processes) (Koivusalo, Wyss et al. 2007) will also be required in New Zealand to ensure a focus on equity of access, but as noted in this research, careful attention needs to be paid to the balance of central regulatory and local decision-making responsibilities and to the clarification of key roles within the sector.

In the NZPHDA model, the appropriate number of local decision-making authorities, in this case, the number of DHBs, is also a key issue. This too has been raised as a key issue in the international literature. Many informants in New Zealand generally feel that 21 DHBs is too many, but for most, concerns over the number of DHBs were not sufficient to suggest that DHBs should be forcefully amalgamated. Some informants doubted that significant savings could be made from such amalgamations, and the majority of informants preferred to leave it to DHBs to work together collaboratively. More often than not, those disagreeing with this view were those who work with a number of (or all of) the DHBs, but even these informants saw significant benefits in the local decision-making arrangements established under the NZPHDA model.

The international literature suggests there is no one optimal size for organisations in health, particularly given the complex range of services delivered in the sector. This would seem to suggest that the current approach of encouraging collaboration is a good way forward. The key will be to ensure that appropriate pressure is placed on DHBs to make efficiency gains, so that they have appropriate incentives to seek out, for themselves, the most appropriate ways of working together.

In the context of the NZPHDA model and where it goes from here, having identified which key goals New Zealand is trying to achieve with its health sector, and which of the goals may be most achievable given the international evidence and the findings from this research, policy makers need to make decisions about whether the current structures adequately support working towards those goals. The next section of this report looks more closely at these issues, in particular in relation to achieving equity or consistency in service delivery.

Achieving local responsiveness through increased local decision-making

If the over-riding goal is to promote local responsiveness in New Zealand, this research suggests that the balance of decision-making needs to further support local decision-making. This research suggests that a rethink of the role of central mechanisms is required to achieve this.

First, there is a need to clarify the role of national Strategies. These have generally been supported within the sector, providing helpful frameworks within which the sector works, and providing a means by which performance of the sector as a whole can be monitored over time. On the other hand, informants have suggested there are too many Strategies. Some have also suggested that there are also too many requirements within existing Strategies, which has resulted in the need for a 'start here' list to focus the work of the sector. Another key concern relates to the lack of funding to support many Strategies, and in some cases, concerns by some stakeholders over there being limited or no implementation planning. And although DHBs have found that their own HNAs and local planning often results in their own local priorities fitting well with the Strategies (no doubt in part because the Strategies themselves are so broad at times), informants have also suggested that the need to focus on key areas (such as the 'start here' list) does limit their flexibility in meeting local needs at times. There is perhaps the need for fewer Strategies; for DHBs to be involved in their development; for funding to be available to support these wherever possible; and for clear responsibility for implementation to lie with DHBs at a local level. Clear performance indicators for different agencies may also assist in ensuring there is greater understanding of which agencies are responsible for which aspects of the Strategy; and reporting could focus on identifying how the different agencies' responsibilities are being monitored and how these contribute to overall health and independence goals.

Second, there is a need for a clearer framework to be developed around issues of national consistency; in particular, what national consistency means for particular services. The following issues need to be considered in relation to future policy work on devolution of funding and decision-making, in particular around what type of consistency is being sought in New Zealand. The following types of consistency and issues need to be considered further:

Consistent funding for services. Historically, some services in New Zealand have been funded through subsidies, which generally have been set nationally to ensure the same level of funding is available to all New Zealanders. Primary health care general medical subsidies, pharmaceutical subsidies and subsidies for rest home care are examples. These subsidies have traditionally been paid ‘on demand’, with funding from central government matched to the costs incurred as people qualify for the subsidies.

Increasingly, however, overall funding (eg to the RHAs, HFA and now the DHBs) or funding to particular services is capped. With the re-introduction of the population-based funding formula for DHBs and the introduction of the PHCS and capitated funding to PHOs, a desire for consistency in funding is now reflected in the funding formula, usually based on need, and adjusted for local factors leading to higher costs in some areas, such as in rural areas or for tertiary hospitals.

Where local organisations need to keep expenditure within capped budgets, they need the ability to either alter the level of subsidy paid to provide services, or the thresholds or criteria for access to care. With any particular service, the key question is which type of consistency is more important – the subsidy level or access? In addition, in some service areas where there are both national subsidies required to be paid for particular services along with national rules for eligibility, those purchasing or delivering care will find that these areas must be funded as a priority, potentially placing pressure on other services.

Consistency in access to services. Governments often have a key goal of ensuring equal access to care for those with equal needs. Thus, New Zealanders may have an expectation of all New Zealanders with particular needs being able to access a service within the same time as other New Zealanders. Putting aside whether the service is of the same standard or quality in all parts of the country, this comes down to two things. One, that the same range of services being delivered around the country. This is where the service coverage framework becomes a significant issue – and some DHBs have felt constrained by the framework, which they see as forcing them to deliver such services. However, equal access is more than this. The second point is therefore that

equal access also requires that people with the same degree of suffering or capacity to benefit to be able to access care in a timely way. It is doubtful that New Zealand has ever had such a degree of consistency of access. It is this consistency of access that we are attempting to achieve in relation to elective surgical services – backed up by waiting times targets and a set of tools aimed at measuring need. However, the policy has proved difficult to implement fully (McLeod, Morgan et al. 2004).

A desire for national consistency in all services would require an approach similar to that developed for elective services for all services, backed up by a monitoring process which aims to bring DHB rates together over time. The more tightly defined are the access requirements, the more funding needs to be matched to local costs/expenditure required for achieving targets, rather than relying on the general funding formula we now use. Where some services have tightly defined access requirements around them, while others do not, spending on services which are less well defined and targeted may gradually become less well supported over time.

As it is, the detailed information required to undertake this degree of planning is not available nationally for many services. It requires a clear understanding of the level of need in a community; of how well that need is being met; of unmet need; and a way of measuring these consistently around the country, with an agreed national threshold for access to services. This is where a local model appears to have distinct advantages over a national approach – DHBs can use a wide range of local data sources, including working groups and other means of engaging with local communities, to identify key needs and gaps. Moreover, they then have the role of balancing these across the range of needs and services they deliver. If, for some reason, need is higher in one DHB than in another for a particular type of service, DHBs can adjust their priority-setting to accommodate this. This approach requires that DHBs should then develop their own skills and processes for deciding on priorities; and determine the best allocation of resources within their districts for themselves.

As it is, there are already examples of where DHBs with more flexibility in decision-making – arising from having no deficits for example or from a focus on developing primary health care more strongly – will be changing the balance of service delivery from that which existed prior to the reforms. This is likely to be leading to differences in service delivery around NZ, bringing into question whether equal access to services may ever be achieved here.

Consistency in ways of delivering services. Another way of thinking about consistency relates to the ways in which services are delivered. For example, decisions are made daily about which professionals deliver which services, where services are located, and over the style of service. Generally, these are the types of decisions which would be considered best made at a local level, in order to tailor services to the needs of those receiving them, as well as to local factors relating to the supply of human resources (eg, in relation to the availability of general medical, nursing and other staff, as well as to specialist medical, nursing and other staff).

Consistency in relation to quality of care. Finally, we can think of consistency in terms of quality of care, where it is desired that the same quality of care be available regardless of where one lives. This may result in particular requirements around training, the availability of specialist care, a desire for particular staff/patient ratios, and so on. In some service areas there are standards of care set out along with auditing requirements (eg, in mental health, DSS, rest home care), while in other areas quality standards are set through accreditation processes. The more specific are standards of care which are set nationally, the more local agencies may find themselves having to fund and support these services to a particular level, which then again impacts on their ability to meet other needs and priorities. This is not to say that there ought not to be minimum standards of care, but that care needs to be taken to set these standards in a way which does not overly constrain organisations trying to meet a range of needs at a local level as well as to remain within budget.

This research has shown examples where DHBs have felt their decision-making ability is compromised by requirements for some forms of national consistency. For example, the service coverage schedule sets out the range of services expected to be provided, while volumes of service are also required in agreements in some areas (for

example, surgical and medical services), and service standards also exist in some key areas, against which providers in particular are audited. If DHBs are to obtain more flexibility and the ability to tailor priorities and services to local needs, there is a need to clarify the role of the service coverage schedule and the extent to which it is expected that minimum volumes of service, standards or requirements for access to services are to be set, reflecting the extent to which variations are appropriate within the NZPHDA environment. There is also a need for clarity about how the service coverage schedule itself is to be reviewed in order to meet population or other health goals, and as new Strategies and services develop. Similarly, DHBs gave examples of where the setting of national prices was seen to impact on their ability to deliver services – both in terms of being seen to increase their costs in ways they found difficult to afford, but also in ways which limited their ability to offer improved terms and conditions in order to maintain or improve service delivery.

Thirdly, a clearer focus on local decision-making will clearly have implications for the role of the Ministry of Health. A number of informants, for example, have suggested that the Ministry focus more on strategic decision-making and streamline its performance monitoring processes.

Finally, this research has identified a number of issues relating to the capability and capacity of agencies in the health sector to undertake their roles effectively. Where DHBs are seen as key local decision-makers, informants in this research have suggested the need for increased planning, purchasing/contracting and monitoring skills, as well as in relation to leadership skills. A number of informants have also suggested a need for improved knowledge and understanding of primary health and disability support services within DHBs, while others have also noted key areas of clinical workforce shortages which urgently need addressing.

Promoting equity of access, ensuring capability and capacity through increased central decision-making?

Although it is easy to reflect on the desirability of allowing the model to develop further to promote local decision-making, the researchers recognise that strong accountability to central government is difficult to avoid in the New Zealand health sector. Central government now funds over \$10 billion worth of health and disability

support services, and Ministers (and Ministries) of Health are made by the nature of our parliamentary system to feel obliged to defend activities and decisions within what is in fact a large and complex sector. The Government may also have a desire for increased consistency in service coverage, access and ways of delivering services than is likely to occur under the current model.

If a decision were made that the current balance of decision-making seems right or even that there is a need to tilt the balance of decision-making towards central decision-making, then the NZPHDA model may require redesigning. In particular, it is likely that the local structural arrangements established under the NZPHDA – for example, local governing Boards and statutory committees, local needs assessments, strategic and annual planning, local purchasing and contracting, and local community engagement – are too cumbersome to support centralised decision-making. If many decisions are to remain centralised, this raises the questions as to why there are 21 DHBs and a strong local structure to support them.

7 Conclusions

The 2001 health reforms are considered by many to have been in part about devolution of funding and decision-making to local agencies (DHBs), in order to increase the role of local communities in decision-making. This research has shown that many of those working in the sector at a local level feel that New Zealand has not sufficiently devolved decision-making to a local level, and that further devolution should occur in future. Many see potential gains in relation to finding local solutions to local problems, while also ensuring that DHBs can make their own financial decisions to ensure they can deliver an appropriate mix of services to best meet local needs while also remaining within budget. This is, however, not a universal view. Those working at a central government level feel less comfortable with a more devolved approach, as the New Zealand population is argued to be likely to continue to hold central government to account for key decisions in health, and as a result of concerns over inequities/inconsistencies in access to services around New Zealand where key decisions are taken locally.

With the reforms now five years old, this is an opportune time for the government to refine the NZPHDA model. Policy makers need to begin by considering what the key goals are for the health sector; in particular, deciding on which goal is paramount – encouraging local responsiveness or promoting a greater degree of equity and national consistency. They then need to consider how the NZPHDA model as currently configured promotes achievement of the paramount goal. A focus on local issues might suggest there will be further gains from greater devolution and less centralised decision-making. A focus on equity of access across regions and a desire for national consistency may require current or even greater levels of centralised decision-making, and some gains in efficiency might then be achieved by reviewing the current structures and roles of DHBs.

Appendix 1

Summary of Findings on Decentralisation as Reported in Peckham et al (2005)

This Appendix briefly summarises the findings from a systematic review of the literature, recently undertaken by Peckham, Exworthy, Powell and Greener (Peckham, Exworthy et al. 2005). The findings are summarised by theme:

In relation to outcomes – Peckham *et al* find that few studies examine the relationship between decentralisation and outcomes, and that those studies that do exist are diverse in terms of context, data, dependent and control variables. Peckham *et al* note that quantitative studies take a fiscal federalism approach, based on assumptions that decentralisation improves outcomes as a result of better local information, better knowledge about local preferences and improved co-ordination, as well as from improved efficiency, accountability, equity, innovation and competition. There are opposing theories, however, which argue in favour of centralisation, through flawed information, economies of scale, higher transaction costs, and equity losses. Peckham *et al* note that any improvements in outcomes therefore occur through improvements in other criteria (eg, such as efficiency), and that it is important to examine how these improvements are achieved. They also suggest that the actual context in which decentralisation occurs is important if decentralisation is to lead to improved outcomes. They also note that much of the evidence (other than that undertaken for Canada by Jiminez and Smith) is from low- to middle-income countries, from a wide range of contexts, and using local government fiscal measures rather than measures of health care decentralisation. These measures are seen to be fairly crude, and although they may measure the degree of local spending as a proportion of national spending, this may not be associated with high degrees of autonomy at a local level. Moreover, studies control for a range of different factors, and Peckham *et al* note that it is not always clear that a different set of control variables might lead to different results.

Peckham *et al* go on to cite evidence that suggests that decentralisation is associated with better outcomes. They note studies in India in rural villages (1979-1994, in relation to child mortality) (Mahal, Srivastava et al. 2000); in India (1990-1997)(Asfaw, Frohberg et al. 2004), which also finds evidence that the effectiveness of fiscal decentralisation increases with the level of political decentralisation; in China (1980-1983, in relation to mortality and in relation to increasing local health expenditure) (Yee 2001); in six developing countries (Argentina, Brazil, Colombia, Philippines, South Africa and Venezuela, in relation to immunisation for measles in children under 12 months, but not for DPT, (Ebel and Yilmaz 2001); in Argentina (1970-1999 in relation to infant mortality, and in reducing regional inequalities (Habibi, Huang et al. 2001). They report findings from (Robalino, Picazo et al. 2001), who analyse data from low and high income countries in relation to infant mortality rates between 1970-1995, finding that decentralisation is associated with lower infant mortality rates, with the marginal benefit greater at low income levels. They also note findings from Khalegian (2003), who also examines the association between decentralisation and immunisation coverage for DPT3 and measles in 140 low and middle income countries between 1980 and 1997, finding that decentralisation improves coverage rates only in low income countries. Peckham *et al* also report on Jiminez and Smith's (2005) focus on decentralisation in health in Canada, using as a measure of decentralisation the proportion of sub national spending to total spending in 10 provinces, recognising that the Canadian system allows for a high degree of autonomy in decision-making at the provincial level. Jiminez and Smith focus on the impact of decentralisation on infant mortality for the period 1979-1995 and find a positive and substantial effect from decentralisation in terms of infant mortality (Peckham, Exworthy et al. 2005, p. 60).

Peckham *et al* conclude that the evidence, though limited, does suggest that decentralisation is associated with better outcomes. They note, however, that the implications for the UK from this evidence are not clear, given that much of the evidence comes from countries with quite different income levels and health systems to those of the UK.

In relation to **processes**, Peckham *et al* focus on theoretical assumptions that decentralisation may lead to more flexibility and faster responsiveness, more effectiveness from knowledge about what is actually happening; more innovation, including from employees actually working with those who use services; and higher morale, more commitment and great productivity (Osborne and Gaebler 1992). It has also been argued that decentralisation is a more democratic approach (Schedler and Proeller 2002); that it leads to improved co-ordination through increased co-operation (Carter 1999); and to new ways of dealing with issues through networks (Kickert, Klijin et al. 1997; Kickert 2001), including through improved communication (Ferlie and Pettigrew 1996).

Problems in examining the impact of decentralisation on these process criteria include difficulties in finding good indicators/measures of process (Goddard, Mannion et al. 1999); the need for clarity about which powers are decentralised and for which services in order to examine whether gaps in service delivery appear (Carter, Klein et al. 1992); concerns over potential losses in economies of scale and scope through decentralisation resulting in greater duplication of administrative functions and/or technologies (Le Grand, Mays et al. 1998; Jessop 1999); and the need to be careful in assuming that decentralisation will work for each and every service (Atkinson, Medeiros et al. 2000). The key issues here then are that there may be a trade-off between responsiveness and economies of scale and scope.

Peckham *et al* report that there is some evidence that decentralisation leads to improvements in processes by empowering employees and improving staff morale (Klijin, Koppenjan et al. 1995; Germain and Spears 1999; Klijin and Koppenjan 2000). They also report evidence from an early study of primary health care groups of improved morale and better inter-professional relationships, as well as some minor changes in some community-based services (Hudson 1999). Drawing on Putnam's (1993) work they also note evidence of improved local democracy where there are existing civil, community-based institutions. On the other hand, Peckham *et al* also report some UK evidence that suggests that councils with a higher level of output provide a better service at lower cost (Boyne 1996), but they go on to note that many academics and commentators now argue that there is no one appropriate scale for organisations in health, given the wide range of services and contexts for service

delivery that exist in health care, and given the need to recognise that large populations in one country may be comparatively small in another.

Overall, Peckham *et al* note that there is a very limited amount of empirical evidence in relation to process measures. They also note that the literature recognises that governments also aim to ensure equity in the distribution of services and resources, and that politicians may never be able to allow full decentralisation, as they find it difficult to resist getting involved in decision-making (Klein 1998; Boyne, Farrell *et al.* 2003).

A further criterion/goal considered by Peckham *et al* is that of **humanity**, that is promoting the wellbeing of local populations or patients, being responsive/accountable to local needs, treating staff well, and enhancing civic participation. Peckham *et al* note that the literature on decentralisation suggests that decentralised organisations are closer to their communities and therefore more likely to be responsive and openly accountable to those communities, as well as more likely to pay greater attention to patient needs. They focus in particular on the way in which organisations treat patient, staff and the wider public.

They find evidence of decentralisation enhancing trust (Perrone, Zaheer *et al.* 2003) and worker empowerment (Sheaff, Schofield *et al.* 2004), as well as of local health agency board members having a greater sense of responsibility to a local community when there is decentralisation (Ashburner and Cairncross 1992; Ashburner and Cairncross 1993). On the other hand, small minority groups may easily be dominated or muted by local majorities, meaning that decentralisation can be detrimental for these groups where majority views dominate (Bjorvathn and Cappelan 2002), although it is noted that when minorities work together nationally, they may have a more powerful voice. In addition, some studies have found evidence that in practice, decentralisation involves an extension of hierarchical control (Sheaff, Schofield *et al.* 2004), and that local managers may not use decentralised powers or might be conditioned by earlier centralised models (Hales 1999).

A further key criterion/goal relates to that of **equity**. Peckham *et al* note the multiple forms of equity that occur in the literature and the ambiguity that often arises where the literature is not clear about the form of equity being discussed or analysed. Equity might imply equal allocation, or equal allocation modified by criteria such as need (which also has multiple definitions, from ill-health or disability through to capacity to benefit), and may apply to funding, availability, access or use of services, or to outcomes. Equity also can be considered in relation to horizontal equity – treating like cases alike; or to vertical equity – treating different cases differently. Equity can also be considered in relation to different geographical areas, social classes, ethnicities, or ages.

Peckham *et al* note that much of the literature assumes that equity will be reduced through decentralisation, through there being greater variations in health service access, provision or use. On the other hand, there is also a literature that suggests that equity can be enhanced through decentralisation, by enabling local organisations to better meet the needs of some groups poorly served by centralised systems, and through distribution of resources towards marginal regions and groups.

Peckham *et al* note that the empirical evidence in relation to equity is in fact limited. They do, however, note that (Rico 2000) has found that in Spain there was a limited increase in regional inequality where regions enjoyed constraints on their fiscal powers, while (Quadrado, Folmer *et al.* 2001) conclude that regional inequality may have been reduced through decentralisation, although it was at that stage too early to draw firm conclusions. GP fundholding schemes in the UK in the 1990s were shown to have led to some reductions in equity, as there was some evidence that patients of fundholding GPs were able to get faster access to care; and there have also been some reports of inequities from countries with strong regionalised structures (including Italy, New Zealand, Canada and Switzerland). Bossert (2000) notes that at times per capita expenditure can increase following decentralisation (of funding), where wealthier areas have tended to spend more than poorer areas, with no direct link to service improvement. A key, then, to promoting equity is to redistribute funding between regions and groups. The literature also notes that standards can be used to try to overcome inequities, but that local autonomy and attempts to meet local needs in

appropriate ways will conflict with national equity goals in relation to access to similar services.

Peckham *et al* note that decentralisation is also theorised to improve **job satisfaction and staff morale**. This can occur through improvements in the ability to manage one's own work, and empowerment of middle managers. On the other hand, decentralisation can potentially undermine management through inadequate skills and competence, and difficulties in recruiting at a local level. They also note problems in researching the effects of decentralisation on staff morale, resulting from difficulties attributing change directly to decentralisation, as opposed to other factors, while some commentators have suggested that some staff may be used to working in a rule-based hierarchy, resulting in problems where decentralisation occurs (Hales 1999).

There is some UK and US evidence to suggest that decentralisation can lead to improved morale (Pennings 1976), empowerment of employees (Germain and Spears 1999), and higher levels of involvement and commitment (Sheaff, Schofield et al. 2004). Studies in non-profit organisations in Israel find decentralised management to be appropriate where there are informal structures and management and high levels of professionalism (Schmid 2002); while reviews of literature relating to surgical teams has found some evidence also to support the notion that decentralisation of decision-making to flexible teams improves worker empowerment and democracy (Craig 2003; Sheaff, Schofield et al. 2004). Studies in the NHS have also shown that local human resources management can lead to changes in working times and shift patterns (Arrowsmith and Sisson 2002). A study of local commissioning also found that decentralised local commissioning was associated with improved morale (Hudson 1999). Other research, however, finds the opposite effects. Several studies have found reduced satisfaction and morale in the face of changes in policy and health sector reform (Hoggett, Hoggett et al. 1996; Bojke, Gravelle et al. 2001; Ahmad and Broussine 2003; Greener 2004). Other studies have found wariness of greater autonomy (Simonis 1995; McDonald and Harrison 2004), or that decentralisation is seen to be a response to or sign of poor management (ManogNegrin 2004); and in one case staff in teams saw decentralisation 'as a despotic extension of hierarchal control' ((Zetka 1998) quoted in (Sheaff, Schofield et al. 2004)). External factors have also been found to be relevant to the impact of decentralisation on morale, such as the

ability to set pay levels locally, the training and experience of managers, and unwillingness to use decentralised decision-making powers.

Overall, Peckham *et al* conclude that the link from decentralisation to improved staff morale is at best equivocal, with a wide variety of factors likely to affect morale and motivation, such that decentralisation may not be the determining factor. They note the comments of Bossert (1996) of the need for central officials to possess skills in policy making and monitoring, while local level officials need operational and entrepreneurial skills. At a local level, there is also a need for the capability to make decisions or take appropriate actions (Anell 2000).

Peckham *et al* then consider the research evidence in relation to **responsiveness and allocative efficiency**. They note that this relates to a number of issues relating to patients, including autonomy for patients to participate in health-related decisions; prompt attention; clarity of communication to patients; access to social support networks and family and community involvement; and choice of health care provider. It also includes the economic goal of allocative efficiency, ie providing the quantity and type of health services desired by society.

Peckham *et al* find reported evidence of increased adaptation and flexibility as a result of decentralisation (Reed and Blunsdon 1998; Sheaff, Schofield et al. 2004) as well as of increased innovation (Rico 2000). Decentralisation in NZ was also found to have lead to reports of increased accountability, commitment and innovation (Malcolm, Alp et al. 1994), while the purchaser-provider split enabled funding to be allocated to indigenous providers (Craig 2003), and similar reforms in Sweden also lead to greater cultural diversity of local services (Blomqvist 2004). On the other hand, Peckham *et al* report that in the UK there are examples of local organisations not being responsive to local populations, due to a high degree of centralisation (Milewa, Valentine et al. 1998; Hales 1999) and fears over destabilising local health economies (Deeming 2004). One study also found that innovation in the USA, UK, Scandinavia and Germany resulted in innovation, and cost inflation (Moran 1994).

A further criterion/goal included in the discussion by Peckham *et al* is that of **adherence to performance targets and evidence-based protocols**. Here, Peckham *et al* note that although this may seem to be at odds with decentralisation, performance targets and evidence-based protocols are a means by which central agencies maintain a connection with local organisations. The assumption here is that decentralisation results in a stronger performance management framework for local organisations, through guidance, monitoring and enforcement (Smith 2002), although the decentralisation-centralisation balance can be affected by ‘the degree to which guidance becomes direction, monitoring, (sic) becomes interference and enforcement becomes control’ (Peckham, Exworthy et al. 2005, p.79).

Peckham *et al* report evidence of a blurring of these roles between the centre and local organisations (Klein and Day 1997; Exworthy, Berney et al. 2002; Ahmad and Broussine 2003; Greener 2004). The nature of the incentives offered can also be important, as can the ability of local organisations and individuals to access resources to bring about change. In relation to adherence to evidence-based protocols, which may improve where staff morale and levels of trust increase as a result of decentralisation, there is a large literature on why practice does not always adhere to evidence (eg (Davies, Nutley et al. 2000; Walshe and Rundall 2001). Peckham *et al* thus note the need for a clear framework within which local organisations can operate, avoiding ambiguity over the extent to which centralised and decentralised decisions can be made. No evidence in support of the proposition that decentralisation improves adherence is reported (other than commentary on the issue), while some evidence suggests that decentralisation may reduce adherence. This is based on examples from Scandinavia (where guaranteed waiting times for hospital treatment was associated with lower local autonomy (Blom-Hansen 1999); a lack of performance accountability in New Zealand such that regional variations in provision were not tackled (Barnett and Newberry 2002); uneven local capacity in New Zealand hindering development of decentralised organisations (Craig 2003); and evidence of restrictions in England on local level freedom of purchasers (Dixon 2004). Some commentators have also suggested that the routine, local practices of professionals are important determinants of local policy, despite central directives (Lipsky 1980), with senior professionals in clans and networks involved in much management of professional groups through clans and across networks (Ferlie and Pettigrew 1996;

Sheaff, Sibbald et al. 2004). Some suggest also the importance of internalising central values, through performance targets or the tenets of evidence-based practice (Deeming 2004), while others note that the development of larger primary care organisations, established in part to improve clinical governance and adherence to protocols, may reduce ‘professional engagement’ as they become more ‘centralised and hierarchical’ (Bojke, Gravelle et al. 2001, p.601).

Peckham *et al* in summarising the evidence note the demise of the ‘star rating’ system of hospital performance in 2005 (Stevens 2005) and the move to clinical governance through clinical leadership and influence in relation to meeting targets and working towards implementing evidence-based protocols. Adherence is therefore likely to depend on whether clinical leaders can ‘maintain collegial identity with the rank-and-file colleagues’ (Peckham, Exworthy et al. 2005, p.81). They also note that no definitive conclusion can be reached on whether decentralisation improves adherence, but that the context in which decentralisation takes place may well be important in aiming to achieve this goal.

In relation to **technical efficiency**, Peckham *et al* focus on how decentralisation may achieve the maximum outputs for the inputs used in service delivery. Theoretical considerations suggest that decentralisation may increase efficiency through reduced bureaucracy, ‘unnecessary’ tiers of administration, ‘better’ performance (through more responsiveness and lower costs) from smaller organisations, which are closer to the communities they serve, greater ability to reduce inefficiencies, and greater experimentation and innovation. On the other hand, decentralisation may result in duplication of services, and size may not be a determining factor in relation to performance. It is also posited that local organisations may be unable or unwilling to press for improvements in performance, and there is a need for ‘effective processes of policy learning/transfer’ (Peckham, Exworthy et al. 2005, p. 82). Further, effective incentives may be needed to encourage the search for efficiencies (Hales 1999), and effective managerial capacity will be important to ensuring efficiency gains can be realised. ‘Spill-over’ effects may also work against achieving efficiency goals, including from ‘free rider’ effects, excessive resource use, and over-provision of services through duplication.

There is limited evidence in support of decentralisation enhancing efficiency. Peckham *et al* cite New Zealand evidence as suggesting that decentralisation has led to increased efficiency and accountability (Malcolm and Barnett 1995); claims of lower transaction costs associated with decentralisation (Manor 1999); and suggestions from commentators that there are likely to be efficiency gains from decentralisation, with one commentator suggesting that transaction costs are not likely to be higher under decentralisation (Levaggi and Smith 2004). Empirical evidence from GP fund-holding is advanced in support of decentralisation leading to efficiency gains, with GP fundholders reducing prescribing costs compared with non-GP fundholders (Peckham and Exworthy 2003). Peckham *et al* also consider efficiency gains from purchaser-provider separation, and contracting out, supported by UK evidence which suggests there was increased patient throughput and reduced length of stay arising from the UK internal market system (Peckham and Exworthy 2003), while Dixon (2004) suggests that the use of a fixed national price for services does provide an incentive for providers to examine organisational efficiency.

Another issue considered in this context relates to organisational size and efficiency. Some commentators support smaller sizes, citing evidence that mergers often fail to deliver on anticipated benefits, due to lack of adequate infrastructure and skilled managers (Bojke, Gravelle *et al.* 2001; Walshe, Smith *et al.* 2004), and that there is no single optimal size for organisations. Drummond (2002) also suggests that seeking organisational mergers in order to reduce costs is ‘misguided’, pointing to central government being more inefficient. Some argue that allocating financial responsibility to lower levels brings improved financial performance (Petretto 2000), while Bankauskaite *et al* (2004) argue that in Italy, regional cost sharing contributed to lower levels of expenditure. Peckham *et al* also cite information from local government suggesting that their view on scale economies have changed over time, by 1995 suggesting that larger authorities do not always perform better.

Peckham *et al* also include evidence about decentralisation hampering technical efficiency, with commentators suggesting scale economies limit the gains from decentralisation, and some evidence to support this, in relation to fiscal centralisation (Van der Laan 1983), or at least showing no differences from decentralisation in India (other than lower levels of spending on primary health care) (Varatharajan,

Thankappan et al. 2004). Rico (Rico 2000) showed cost containment problems under a decentralised model; and both Spain and the UK have used tighter financial controls to increase efficiency (Arrowsmith and Mosse 2000; McEldowney 2003). Others have argued against markets and competition, citing concerns over the impact on 'network-based services' with a loss of scale economies and control over scarce financial resources (World Bank no date), concerns over managerial or technical capacity, and the potential for cost inflation from innovation through market reforms (Moran 1994). Others conclude that organisation size is only one factor in determining performance (Bojke, Gravelle et al. 2001; Walshe, Smith et al. 2004), complicated in health by the multiple functions being performed, and by the potential differences in scale between an efficient scale of activity and the level at which citizens vote (Kleinman 2002). Kleinman *et al* (2002) also point to 'limited evidence of improved efficiency from local tax raising powers (as opposed to central grants)' and they highlight the conflict between identifying an efficient scale for economic activity and the spatial scale at which citizens vote.

Overall, Peckham *et al* conclude there is limited evidence available in relation to efficiency, but what there is supports a positive relationship between decentralisation and efficiency, although the design of policies may compromise potential gains. They also point to stronger evidence (for both efficiency and equity reasons) to support centralised financing (King's Fund 2002; Wanless 2002).

The final criterion/goal included in Peckham *et al*'s work is that of **accountability**. This incorporates accountability to others, ie being held to account for actions taken; and transparency, ie being seen to be open to scrutiny. Decentralisation is held to increase accountability, through enhancing civic participation; neutralising local elites; increasing political stability (De Vries 2000); and through agencies being more conscious of their responsibility to local communities (Hambleton, Hoggett et al. 1996). Key issues of relevance to this debate include election turnout and representativeness (with low turn out rates in local elections in Canada (13% Quebec CHCs) and the UK (De Vries 2000)); and the recognition that there are a number of dimensions to accountability (Klein 2003).

Peckham *et al* go on to cite evidence showing more openness, transparency, consultation and scrutiny in relation to budgets in the UK (Ezzamel, Hyndman et al. 2004), and in New Zealand (Malcolm, Alp et al. 1994; Malcolm and Barnett 1995). Ferlie and Pettigrew (Ferlie and Pettigrew 1996) found greater central accountability in HQ reforms; with Ashburner and Cairncross (Ashburner and Cairncross 1992; Ashburner and Cairncross 1993) finding local board members are likely to feel some accountability to the local community. Other studies have found the opposite, for example in Norway (Elstad 1990), with Fattore (2000) suggesting the need for a greater role for the centre in relation to accountability, and Hill and Pickering (Hill and Pickering 1986) finding problems with co-ordination, accountability and control in organisations. In New Zealand, it has been noted that decentralisation has been accompanied by monitoring, performance management and accountancy control (Craig 2003).

Thus, overall the evidence in relation to accountability is mixed, although Peckham *et al* go on to suggest that decentralisation may increase the complexity of accountability as it leads to a greater number of accountabilities.

References

- Aday, L. A. and R. Andersen (1981). "Equity of access to medical care: A conceptual and empirical overview." Medical Care 19(12, Supplement): 4-27.
- Ahmad, Y. and M. Broussine (2003). "The UK public sector modernization agenda: reconciliation and renewal?" Public management review 5(1): 45-32.
- Ajwani, S., T. Blakely, B. Robson, M. Tobias and M. Bonne (2003). Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999. Wellington, Public Health Intelligence.
- Allen, P. (2006). "New localism in the English National Health Service: What is it for?" Health Policy 79: 244-252.
- Andrulis, D. P. (1998). "Access to care is the centrepiece in the elimination of socioeconomic disparities in health." Ann Intern Med 129: 412-16.
- Anell, A. (2000). "Decentralising Swedish health care." Eurohealth 6(3): 34-35.
- Arrowsmith, J. and P. Mosse (2000). "Health care reform and the working time of hospital nurses in England and France." European Journal of Industrial Relations 6(3): 283-306.
- Arrowsmith, J. and K. Sisson (2002). "Decentralization in the public sector; the case of the UK National Health Service." Industrial Relations 57(2): 354-380.
- Asfaw, A., K. Froberg, K. S. James and J. Juting (2004). Modelling the Impact of Fiscal Decentralisation on Health Outcomes: Empirical Evidence from India. Bonn, ZEF.
- Ashburner, L. and L. Cairncross (1992). "Just trust us." Health Service Journal 102(5302): 20-22.
- Ashburner, L. and L. Cairncross (1993). "Membership of the 'new style' health authorities: continuity of change?" Public Administration 71(3): 357-75.
- Ashton, T. (1993). "From Evolution to Revolution: Restructuring the New Zealand Health System." Health Care Analysis 1(1): 57-62.
- Ashton, T. (1999). The Health Reforms: To Market and Back? Redesigning the welfare state in New Zealand: Problems, Policies, Prospects. J. Boston, P. Dalziel and S. St John. Auckland, Oxford University Press: 134-153.
- Atkinson, S., R. Medeiros et. al (2000). "Going down to the local: incorporating social organisation and political culture into assessments of decentralised health care." Social science and medicine 51(4): 619-636.
- Bankauskaite, V., R. Saltman and K. Vrangbaek (2004). The role decentralization of European health care systems. London, Report to Institute for Public Policy Research.

Barnett, P. and C. Clayden (2007). Governance in District Health Boards. Health Reforms Research Project Report No. 2. Wellington, Health Services Research Centre.

Barnett, P. and S. Newberry (2002). "Reshaping community mental health services in a restructured state: New Zealand 1984-1997." Public management review 4(2): 187-208.

Bjorvathn, K. and A. Cappelán (2002). Decentralization and the fate of minorities, Centre for Economic Studies Munich University.

Blom-Hansen, J. (1999). "Policy-making in central-local government relations: balancing local autonomy, macroeconomic control and sectoral policy goals." Journal of public policy 19(3): 237-264.

Blomqvist, P. (2004). "The choice revolution: privatisation of Swedish Welfare Services in the 1990s." Social Policy and Administration 38(52): 139-155.

Bojke, C., H. Gravelle and D. Wilkin (2001). "Is bigger better for primary care groups and trusts?" British Medical Journal 322: 599-602.

Bossert, T. (1996). Decentralization. Health policy and systems development: an agenda for research. K. Janovsky. Geneva, World Health Organization: Chapter 9 (147-159).

Bossert, T. (1998). "Analyzing the decentralization of health systems in developing countries: decision-space, innovation and performance." Social Science and Medicine 47(10): 1513-1527.

Bossert, T. (2000). Decentralization of health systems in Latin America: a comparative analysis of Chile, Colombia and Bolivia, Harvard School of Public Health. June.

Bowling, A. and S. Ebrahim, Eds. (2005). Handbook of Health Research Methods: Investigation, Measurement and Analysis. Maidenhead, Open University Press.

Boyne, G. (1996). "Scale, performance and local government reorganization: an analysis of non-metropolitan districts." Public money and management July-Sept: 55-60.

Boyne, G., C. Farrell, J. Law, M. Powell and R. Walker (2003). Evaluating Public Management Reforms. Buckingham, Open University Press.

Brunton, W. (1983). "Hostages to history." New Zealand Health Review 3(2): 3-6.

Carter, A. (1999). "Game theory and decentralisation." Journal of applied psychology 16(3): 223-234.

Carter, N., R. Klein and P. Day (1992). How organisations measure success: the use of performance indicators in government. London, Routledge.

Coster, G. (2004). Health Needs Assessment: Impact on Planning and Purchasing in the Public Health Sector in New Zealand. Public Policy. Wellington, Victoria University of Wellington.

Coster, G., N. Mays, C. Scott and J. Cumming (2006). The impact of health needs assessment and prioritisation on District Health Board planning in New Zealand Auckland, University of Auckland.

Craig, D. (2003). "Reterritorialising health: inclusive partnerships, joined-up governance and common accountability platforms in third way New Zealand." Policy and Politics 31(3): 335-352.

Cumming, J. and N. Mays (2002). "Reform and counter-reform: how sustainable is New Zealand's latest health system restructuring?" Journal of Health Services Research and Policy 7(Supplement 1): 46-55.

Cumming, J. and G. Salmond (1998). Reforming New Zealand health care. Markets and health care: a comparative analysis. W. Ranade. New York, Addison Wesley Longman.

Cumming, J. and C. Scott (1998). "The role of outputs and outcomes in purchaser accountability: Reflecting on New Zealand experiences." Health Policy 46: 53-68.

Davies, H., S. Nutley and P. Smith (2000). What works: evidence-based policy and practice in the public services. Bristol, Policy Press.

De Vries, M. (2000). "The rise and fall of decentralization: a comparative analysis of arguments and practices in European countries." European Journal of Political Research 38: 193-224.

Deeming, C. (2004). "Decentring the NHS: a case study of resource allocation decisions within a health district." Social Policy and Administration 38(1): 57-72.

Devlin, N. and D. O'Dea (1998). Hospitals. The structure and dynamics of New Zealand industries. M. Pickford and A. Bollard. Palmerston North, Dunmore Press: 287-321.

Dew, K., J. Cumming, D. McLeod, S. Morgan, E. Mckinlay, A. Dowell and T. Love (2005). "Explicit rationing of elective services: implementing the New Zealand reforms." Health Policy 74: 1-12.

Dixon, J. (2004). "Payment by results: new financial flows in the NHS." British Medical Journal 328: 969-970.

Ebel, R. and S. Yilmaz (2001). On the measurement and impact of fiscal decentralisation. Paper presented on the symposium of public finance in developing countries: essays in honor of Richard M. Bird.

Elstad, J. (1990). "Health services and decentralized government: the case of primary health services in Norway." International Journal of Health Services 20(4): 545-559.

European Observatory (2000). Norway: Health Care Systems in Transition. Copenhagen, European Observatory on Health Care Systems.

Exworthy, M., L. Berney and M. Powell (2002). "How great expectations in Westminster may be dashed locally: the local implementation of national policy on health inequalities." Policy and Politics 30(1): 79-96.

Ezzamel, M., N. Hyndman, A. Johnsen, I. Lapsley and J. Pallot (2004). "Has devolution increased democratic accountability?" Public money and management 24(3): 145-152.

Fattore, G. (2000). "State, regions and politics in the Italian healthcare system." Eurohealth 6(3): 32-33.

Ferlie, E. and A. Pettigrew (1996). "Managing through networks: some issues and implications for the NHS." British journal of Management 7: S81-S99.

Flood, C. and D. G. Sinclair (2005). "Steering and rowing in healthcare: the devolution option." Healthcare Quarterly 8(1): 54-57.

Germain, R. and N. Spears (1999). "Quality management and its relationship with organizational context and design." International Journal of Quality and Reliability Management 16: 371-391.

Goddard, M., R. Mannion and P. C. Smith (1999). "Assessing the performance of NHS hospital trusts: the role of 'hard' and 'soft' information." Health Policy. 48(2): 119-34.

Goodhead, A. and J. Cumming (2005). Regional Approaches to Mental Health: A Sector View and Beyond. Wellington, Ministry of Health and Mental Health Commission.

Greener, I. (2004). "The three moments of New Labour's health policy discourse." Policy and Politics 32(3): 303-316.

Guald, R. (2001). Revolving Doors: New Zealand's Health Reforms. Wellington, Institute of Policy Studies and Health Services Research Centre.

Habibi, N., C. Huang, D. Miranda, V. Murillo, G. Ranis, M. Sarkar and F. Stewart (2001). Decentralization in Argentina. New Haven, Economic Growth Centre, Yale University.

Hales, C. (1999). "Leading horses to water? the impact of decentralization on managerial behaviour." Journal of Management Studies 36(6): 831-851.

Hambleton, R., P. Hoggett and K. Razzaque (1996). Freedom Within Boundaries. Developing Effective Approaches to Decentralisation. London, Local Government Management Board.

Hay, I. (1989). The Caring Commodity: The Provision of Health Care in New Zealand. Auckland, Oxford University Press.

Health Benefits Review (1986). Choices for Health Care: Report of the Health Benefits Review. Wellington, Health Benefits Review.

Hill, C. and J. Pickering (1986). "Divisionalization, Decentralization and performance in large United Kingdom companies." Journal of Management Studies 23(1): 26-50.

Hoggett, P., R. P. Hoggett and K. Razzaque (1996). Freedom within boundaries. Developing effective approaches to decentralization. London, Local Government Board.

Hospital and Related Services Taskforce (1988). Unshackling the Hospitals. Wellington, Hospital and Related Services Taskforce.

Hudson, B. (1999). "Decentralisation and Primary Care Groups: a paradigm shift for the NHS in England?" Policy and Politics 27(2): 159-172.

Hurley, J., S. Birch and J. Eyles (1995). "Geographically-decentralized planning and management issues in health care: some informational issues and their implications for efficiency." Social Science and Medicine 41(1): 3-11.

Health Reforms 2001 Research Team (2003). Interim Report on Health Reforms 2001 Research Project. Wellington, Health Services Research Centre.

Jessop, B. (1999). "The Changing Governance of Welfare: Recent Trends in its Primary Functions, scale and modes of Coordination." Social Policy and Administration 33: 348-359.

Jimenez, D. and P. C. Smith (2005). Decentralisation of Health Care and its Impact on Health Outcomes. York, Department of Economics and Related Studies, University of York.

Johnsen, J. R. (2006). Norway: Health Care Systems in Transition. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Khaleghian, P. (2003). "Decentralization and public services: the case of immunization." Social Science & Medicine 59: 163-183.

Kickert, W. (2001). "Public management of hybrid organizations: governance of quasi-autonomous executive agencies." International Public Management Journal 4: 135-50.

Kickert, W., E. Klijin and J. Koppenjan (1997). Managing complex networks: strategies for the public sector. London, Sage.

King's Fund (2002). The Future of the NHS: A Framework for Debate. Discussion Paper. London, King's Fund.

King, H. A. (2000a). Changes in Health Sector.

King, H. A. (2000b). First Reading, NZPHD Bill.

King, H. A. (2000c). Press Release: About the New Zealand Health and Disability Strategy.

King, H. A. (2000d). Press Release: NZ Public Health and Disability Bill reported back.

King, H. A. (2000e). Third Reading, NZPHD Bill.

King, H. A. (no date-a). Health and Disability Sector Changes and Their Implementation: Memorandum to Cabinet Business Committee.

King, H. A. (no date-b). Memorandum to Cabinet Social Policy and Health Committee: District Health Board Accountability Arrangements.

King, H. A. (no date-c). Memorandum to Cabinet Social Policy and Health Committee: Governance of District Health Boards.

King, H. A. (no date-d). Memorandum to Cabinet Social Policy and Health Committee: The Division of Roles Between District Health Boards and the Ministry of Health.

King, H. A. (no date-e). Memorandum to Cabinet Social Policy and Health Committee: The Role of District Health Boards and the Division of Functions Between District Health Boards and the Ministry of Health.

Klein, R. (1998). "Why Britain is reorganizing its national health service - yet again." Health affairs 17: 111-125.

Klein, R. (2003). "Governance for NHS foundation trusts." British Medical Journal 326: 174-175.

Klein, R. and P. Day (1997). Steering But Not Rowing? The Transformation of the Department of Health: A Case Study. Bristol, Policy Press.

Kleinman, M., et al (2002). Links between finance and non-finance elements of local government. A literature review. London, Office of the Deputy Prime Minister.

Klijin, E. and J. Koppenjan (2000). "Public Management and Policy Networks: Foundations of a Network Approach to Governance." Public Management 2: 135-158.

Klijin, E., J. Koppenjan and K. Termeer (1995). "Managing Networks in the Public Sector: A Theoretical Study of Management Strategies in Policy Networks." Public Administration 73: 437-454.

Koivusalo, M., K. Wyss and P. Santana (2007). Effects of decentralization and recentralization on equity dimensions of health systems. Decentralization in Health Care: Strategies and Outcomes. R. Saltman, V. Bankauskaite and K. Vrangbaek. Maidenhead, Open University Press: 189-205.

Le Grand, J., N. Mays and J.-A. Mulligan (1998). Learning From the NHS Internal Market: A Review of the Evidence. London, King's Fund Publishing.

Levaggi, R. and P. Smith (2004). Decentralization in Health care: lessons from public economics, York University.

Lewis, S. and D. Kouri (2004). "Regionalization: Making Sense of Canadian Experience." HealthCare Papers 5(1): 12-31.

Lipsky, M. (1980). Street level Bureaucracy. New York, Russell Sage foundation.

Mahal, A., V. Srivastava and G. Veenstra (2000). Decentralization and its impact on public service provision on health and education sectors: the case of India. Governance, Decentralization and Reform in China, India, and Russia. J. Dethier. London, Kluwer Academic Publishers and ZEF.

Malcolm, L. (1990). Decentralization of health service management: a review of the New Zealand experience. Health System Decentralization: Concepts, Issues and Country Experience. A. Mills, J. P. Vaughan, D. L. Smith and I. Tabibizadeh. Geneva, World Health Organization: 81-94.

Malcolm, L., B. Alp and J. Bryson (1994). "Decentralization of general management within New Zealand health system." Health Services Management Research 7(4): 220-228.

Malcolm, L. and P. Barnett (1995). "Decentralization, Integrity and accountability: perceptions of New Zealand's top health service managers." Health Services Management Research 8(2): 121-134.

ManogNegrin, R. (2004). "Employee empowerment in public human service organizations." Social Work and Social Sciences Review 9: 23-41.

Manor, J. (1999). The political economy of democratic decentralization. Washington DC, World Bank.

Mays, N., J. Cumming and T. Tenbenschel (2007). Health Reforms 2001 Research: Overview Report. Health Reforms Research Project Report No.1. Wellington, Health Services Research Centre.

McDonald, R. A. and S. Harrison (2004). "Autonomy and modernisation: the management of change in an English primary care trust." Health and Social Care in the Community 12(3): 194.

McEldowney, J. (2003). "Public management reform and administrative law in local public service provision in the UK." International review of administrative sciences 69(1): 69-82.

McLeod, D., J. Cumming, A. Raymont, T. Dowell, S. White, K. Dew, I. Martin, L. Gallagher and A. Van Rij (2002). Pathways to Care and Outcomes for Elective Surgery: A Prospective Cohort Study. Wellington, Application to the HRC, November 1.

McLeod, D., K. Dew, S. Morgan, A. Dowell, C. J, D. Cormack, E. McKinlay and T. Love (2004). "Equity of access to elective surgery: reflections from NZ clinicians." Journal of Health Services Research and Policy 9(Supplement 2): S2: 41-47.

- McLeod, D., S. Morgan, E. McKinlay, K. Dew, J. Cumming, T. Dowell and T. Love (2004). "Use of, and attitudes to, clinical priority assessment criteria in elective surgery in New Zealand." Journal of Health Services Research and Policy 9(2): 91-99.
- McLeod, D., S. White, E. McKinlay, K. Dew, J. Cumming, T. Dowell, R. Perera, T. Love and A. Raymont (2002). CPAC Evaluation Project: Descriptive Study. Wellington, Unpublished report to the Ministry of Health, Departments of General Practice, Wellington School of Medicine and Health Sciences and Health Services Research Centre.
- Milewa, T., J. Valentine and M. Calnan (1998). "Managerialism and active citizenship in Britain's reformed health service: power and community in an era of decentralisation." Social science and medicine 47(4, August): 507-517.
- Mills, A. (1990). Decentralization concepts and issues: A review. Health System Decentralization: Concepts, Issues and Country Experience. A. Mills, J. P. Vaughan, D. L. Smith and I. Tabibzadeh. Geneva, World Health Organisation: 11-42.
- Ministry of Health (2000). Social Inequalities in Health: New Zealand 1999. Wellington, Ministry of Health.
- Ministry of Health (2004). A Portrait of Health: Key Results of the 2002/03 New Zealand Health Survey. Wellington, Ministry of Health.
- Ministry of Health (2006). Tatau Kahukura: Māori Health Chart Book. Wellington, Ministry of Health.
- Ministry of Health and Ministry of Pacific Island Affairs (2004). Tupu Ola Moui: Pacific Health Chart Book 2004. Wellington, Ministry of Health.
- Moran, M. (1994). "Reshaping the health-care state." Government Opposition 29(1): 48-62.
- Musgrave, R. M. (1959). The Theory of Public Finance. New York, McGraw Hill.
- New Zealand Government (2000a). New Zealand Public Health and Disability Act.
- New Zealand Government (2000b). New Zealand Public Health and Disability Bill, New Zealand Government.
- Oates, W. E. (1972). Fiscal Federalism. New York, Harcourt Brace Jovanovich.
- Osborne, D. and T. Gaebler (1992). Reinventing government: how the entrepreneurial spirit is transforming the public sector. Reading, Massachusetts, Addison-Wesley.
- Patton, M. Q. (2002). Qualitative Research and Evaluation Methods. Thousand Oaks, Sage Publications.
- Peckham, S. and M. Exworthy (2003). Primary Care in the UK. Policy, organisation and management, Palgrave, Macmillan.

Peckham, S., M. Exworthy, M. Powell and I. Greener (2005). Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England. London, NCCSDO.

Pennings, J. (1976). "Dimensions of organizational influence and their effectiveness correlates." Administrative Science Quarterly December(21): 688-699.

Perrone, V., A. Zaheer and B. McEvily (2003). "Free to be trusted? Organizational Constraints in boundary spanners." Organization science 14(4): 422-439.

Petretto, A. (2000). "On the cost-benefit of the regionalisation of the health service." Economics of governance 1: 213-232.

Putnam, R. (1993). Making Democracy Work: Civic Conditions in Modern Italy. Princeton, Princeton University Press.

Quadrado, L., H. Folmer and S. Loman (2001). "Regional inequality in the provision of health care in Spain." Environment and Planning 33: 783-798.

Reed, K. and B. Blunsdon (1998). "Organizational flexibility in Australia." International Journal of Human Resource Management 9: 457-477.

Rico, A. (2000). "Health policy under asymmetric federalism: 20 years of regional devolution in Spain." Eurohealth 6(3): 28-29.

Robalino, D., O. Picazo and A. Voetberg (2001). Does fiscal decentralization improve health outcomes? Evidence from a cross-country analysis. Washington DC, World bank, Africa Technical Families, Human development 1.

Rondinelli, D. (1983). "Implementing decentralization programmes in Asia: a comparative analysis." Public Administration and Development 3(3): 181-207.

Saltman, R., V. Bankauskaite and K. Vrangbaek (2007). Introduction: the question of decentralization. Decentralization in Health Care: Strategies and Outcomes. R. Saltman, V. Bankauskaite and K. Vrangbaek. Maidenhead, Open University Press: 1-8.

Saltman, R. B. and V. Bankauskaite (2006). "Conceptualizing decentralization in European health systems: a functional perspective." Health Economics, Policy and Law 1: 127-147.

Schedler, K. and I. Proeller (2002). A perspective from mainland Europe. New public management: current trends and future prospects. K. McLaughlin, S. Osbourne and E. Ferlie. London, Routledge: 297-313.

Schmid, H. (2002). "Relationships between organizational properties and organizational effectiveness in the three non-profit human service organizations." Public Personal Management 31(3): 377-395.

Sheaff, R., J. Schofield, B. Dowling, M. Marshall and R. McNally (2004). Organisational factors and performance: a review of the literature. London, SDO.

Sheaff, R., B. Sibbald, S. Campbell, M. Roland, M. Marshall, S. Pickard, L. Gask, A. Rogers and S. Halliwell (2004). "Soft governance and attitudes to clinical quality in English general practice." Journal of Health Services Research and Policy. 9(3): 132-8.

Simonis, J. (1995). "Decentralization in the Netherlands: an analysis of administrative differentiation." Local government studies 212: 31-45.

Slater, M. (2006). Responsibility for Public Health in New Zealand: Research Project Report for MAPP 580. Wellington, Health Services Research Centre.

Smith, P. C. (2002). "Performance management in British health care: Will it deliver?" Health Affairs 21(3): 103.

Stevens, S. (2005). "Battles for 2005." Health Services Journal Retrieved 12 January, 2005.

Van der Laan, M. (1983). "Politics, economics and policy: the effects of the political structure centralization and national affluence on health expenditures." International social science review 58(1): 30-44.

Varatharajan, D., R. Thankappan and S. Jatapalan (2004). "Assessing the performance of primary health care centres under decentralized government in Kerala, India." Health policy and planning 19(1): 41-51.

Vedung, E. (1997). Public Policy and Program Evaluation. New Brunswick, Transaction Publishers.

Walshe, K. and T. Rundall (2001). "Evidence-based management: from theory to practice in healthcare." Milbank Quarterly 79(3): 429-457.

Walshe, K., J. Smith, J. Dixon, N. Edwards, D. Hunter, N. Mays, C. Normand and R. Robinson (2004). "Primary care trusts." British Medical Journal Oct, 329: 871-872.

Wanless, D. (2002). Securing Our Future Health: Taking A Long Term View - Final Report. London, HM Treasury.

World Bank. (no date). "Web-based reports on 'Service Delivery', 'Why, What, Where', 'Impacts', 'Inter-governmental Fiscal Relations'." from <http://www1.worldbank.org/publicsector/decentralization>.

Yee, E. (2001). The effects of fiscal decentralization on health care in China, Princeton University.

Zetka, J. R. (1998). "The technological foundations of task co-ordinating structures in new work organizations: theoretical notes from the case of abdominal surgery." Work and Occupations 25: 356-79.