



**Health Reforms 2001 Research Project**

**Report No. 8**

**OVERVIEW REPORT OF THE RESEARCH IN FIVE  
CASE STUDY DISTRICTS**

**Anne Goodhead, Pauline Barnett, Clare Clayden,  
Marie Russell, Toni Ashton, Tim Tenbensen,  
Tai Walker, Amohia Boulton, Sue Buckley**

**On Behalf of the Health Reforms 2001 Research Team**

**August 2007**





## **Health Reforms 2001 Research Project**

### **Report No. 8**

# **OVERVIEW REPORT OF THE RESEARCH IN FIVE CASE STUDY DISTRICTS**

**Anne Goodhead, Pauline Barnett, Clare Clayden,  
Marie Russell, Toni Ashton, Tim Tenbensen,  
Tai Walker, Amohia Boulton, Sue Buckley**

**On Behalf of the Health Reforms 2001 Research Team**

**August 2007**

Published By  
Health Services Research Centre  
Victoria University of Wellington  
©2007 Health Reforms 2001 Research Team

Additional copies available at [www.vuw.ac.nz/hsrc](http://www.vuw.ac.nz/hsrc)  
Or from Maggy Hope [maggy.hope@vuw.ac.nz](mailto:maggy.hope@vuw.ac.nz) 04 463 6565



# Table of Contents

Executive Summary .....	v
Acknowledgements .....	xxxv
Abbreviations .....	xxxvi
1 Introduction .....	1
1.1 Background to the Project .....	1
1.2 Overall Methodology .....	1
1.3 Research Methods .....	2
1.4 Characteristics of the DHBs .....	3
1.5 Caveats to the Report .....	4
1.6 Form of the Report .....	5
2 Governance .....	7
2.1 Legislative Framework .....	7
2.2 Board Processes and Procedures .....	9
2.3 Board Membership .....	21
2.4 Representation .....	22
2.5 Board Performance .....	23
2.6 The Role of the Board .....	26
2.7 Board and Management Relations .....	27
2.8 The Role of Clinicians .....	29
2.9 Board Accountability .....	32
2.10 Statutory Committees .....	37
2.11 Committees Other Than the Statutory Committees .....	57
2.12 Costs and Benefits of Statutory Committees .....	59
3 Strategic Decision-Making .....	61
3.1 Context .....	61
3.2 Health Needs Assessment .....	62
3.3 Strategic Planning .....	65
3.4 Community Engagement and Consultation .....	69
3.5 Prioritisation .....	75
4 Finance, Funding and Contracting .....	80
4.1 Financial Position .....	80
4.2 Population Based Funding Formula (PBFF) .....	82
4.3 Deficit Management .....	85
4.4 Devolution of Contracts .....	89
4.5 Contracting Relationship and Negotiation .....	91
4.6 Form of Contracts .....	94
4.7 Purchasing or Providing .....	95
4.8 Capital Development Costs .....	96
4.9 Lead DHB Contracts .....	96
4.10 Monitoring of Contracts .....	97

5	Devolution and Sector Relationships.....	99
5.1	Context.....	99
5.2	The DHB and Ministry of Health Relationship.....	100
5.3	Role of Clinicians.....	107
5.4	Devolution of Funds for Older People with Disability.....	109
5.5	Other Disability Sector Issues.....	113
5.6	District Health Boards of New Zealand (DHBNZ).....	114
5.7	Capacity and Capability Issues.....	116
5.8	Collaboration With Other DHBs.....	122
5.9	Shared Service Agencies (SSAs).....	124
6	Service Areas.....	125
6.1	Devolution of Primary Health Care.....	125
6.2	Public Health.....	135
6.3	Mental Health Sector.....	137
6.4	Rural Sector.....	139
6.5	Secondary Services.....	140
7	The DHB Model.....	141
7.1	Comparison with Previous Models of Health Care Delivery.....	141
7.2	Strengths of the DHB Reforms.....	145
7.3	Weaknesses of the DHB Reforms.....	147
7.4	Potential Improvements to the Model.....	151
8	Implications.....	155
8.1	With Regard to the DHB Model.....	153
8.2	With Regard to Governance.....	156
8.3	With Regard to Strategic Decision-Making.....	159
8.4	With Regard to Finance, Purchasing and Contracting.....	160
8.5	With Regard to Devolution and Sector relationships.....	161
	References.....	163

## 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*

The project was funded jointly by the Health Research Council of New Zealand and by the Ministry of Health, the Treasury and the State Services Commission through a grant from a Ministry of Research, Science, and Technology Departmental Contestable Research Pool. We are grateful to them for their funding of this research and for the excellent support and advice they provided during the project.

The Research Team warmly acknowledges the support of Board members, DHB staff, providers and stakeholders who have contributed to the various strands of this research. We thank all those who so willingly shared their knowledge and opinions with us.

## Research Team Members

Research team members in August 2007 were:

- Dr Jacqueline Cumming, Director, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Associate Professor Toni Ashton, Centre for Health Services Research and Policy, University of Auckland
- Associate Professor Pauline Barnett, Department of Public Health and General Practice, University of Otago, Christchurch
- Dr Tim Tenbenschel, Centre for Health Services Research and Policy, University of Auckland
- Professor Nicholas Mays, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington and the London School of Hygiene and Tropical Medicine
- Tai Walker, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Dr Amohia Boulton, Te Pūmanawa Hauora, Massey University
- Dr Lynne Pere, Senior Research Fellow – Māori, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Kirsten Smiler, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Larna Kingi, Research Assistant, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Marie Russell, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Sue Buckley, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Janet McDonald, Research Assistant, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Clare Clayden, Senior Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Marianna Churchward, Research Assistant, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Fuafiva Fa'alau, Independent researcher, Pacific health
- Lanuola Asiasiga, Independent researcher, Pacific health
- Hilary Stace, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington.

We would also like to thank the following research team members for their earlier contributions to this research: Professor Gregor Coster and Professor Michael Powell, University of Auckland; Professor Chris Cunningham, Dr Cindy Kiro, Dr Stephanie Palmer and Dr Maureen Holdaway, Massey University; Dr Lou Gallagher, Mili Burnette, Dr Megan Pledger Celia Murphy, Dr Roshan Perera, Anne Goodhead, Nicola Grace and Anna Lloyd, Health Services Research Centre; Kiri Simonsen, Stephen Lungley, Margaret Cochrane and Siân French, Ministry of Health; and Jo Davis, National Health Service Management Trainee.

## **Executive Summary**

This report takes an overview of the five case studies conducted as part of the 2001 Health Reforms Evaluation research project. By drawing out the similarities and differences between the five DHBs, the implementation of the health care system introduced by the New Zealand Public Health and Disability Act 2000 is examined through its application in a selected group of DHBs. As the focus of the evaluation is the model rather than any one DHB's performance, the individual DHBs remain nameless. This report is one of a series examining aspects of the 2001 Health Reforms.

The research was conducted between 2002 and 2004. The methodology used in each case study combined interviews, document analysis and Board observations. The interviews were conducted in two phases: 2002 through to early 2003, and during 2004. Interview informants included DHB personnel, Board and statutory committee members, providers and other stakeholders.

Although the interview schedules for different roles were common to the five case studies, there was some adaptation to the local circumstances. Furthermore, informants' viewpoints inevitably reflected the particular concerns and issues of that DHB. This report is based entirely on the case study reports and therefore does not draw directly on the interview material or DHB documents.

## **Summary of Findings**

### **Governance**

#### ***Board Processes and Procedures***

By the end of the research period all case study Boards were meeting monthly.

The five Boards varied in the degree to which they attempted to make the meetings accessible to the public. Two Boards varied the location around the district and one of these Boards also added in a public forum prior to the meeting to give the public the opportunity to ask questions about local health and disability services. These two Boards have adopted a culture of accessibility which includes giving members of the public some opportunity to speak at Board meetings. These boards are attended more by members of the public compared with the Boards which are less accessible and more formal.

The culture of the five Boards varied. The two which were accessible to the public were also relatively informal and more relaxed. One of these two encouraged all who had something to contribute to speak up, and the second of these gave speaking rights to the public where possible if time permitted and by prior arrangement. A third Board was described as sometimes tense and dysfunctional. This did sometimes allow public submissions but was selective about who was allowed to speak. The other two Boards were both more formal and used other forums to debate issues out of the public domain. Few visitors attended these latter two Board meetings. The Chair was particularly influential in setting the tone of meetings and also was a key person in setting the agenda.

All case studies noted the steep learning curve for members of the Boards as they gained understanding of the sector, their accountability and how to work together as a team.

## ***Transparency***

All of the case studies advertised forthcoming meetings and made these Board and committee meetings open to the public. Other ways transparency is promoted is by posting the agenda and minutes on the website and making other documents available. Although all of the case study Boards used some public excluded session time, the degree to which this was used varied considerably. The main purpose of these sessions was to protect privacy in matters of commercial sensitivity, personnel, complaints and issues to do with individual clinical care.

Most of the case studies reported members becoming more relaxed about being open to the public over the research period. The benefits of transparency were judged to be greater than any perceived disadvantages. Transparency was seen as the key to engagement of the public to raise awareness and knowledge of health matters, which was expected to result in more active participation in health promoting behaviour and more realistic expectations of the health services. Transparency was also seen as facilitating accountability. Those who held lingering concerns considered the debate over sensitive issues was likely to be more forthright without the public in attendance and were disinclined to air disagreement in public.

## ***Conflicts of Interest***

All of the case studies kept a conflict of interest register. Where there is a known conflict of interest, that member usually abstains from the debate or vote on that matter.

At least one case study noted some ambiguity in defining conflict of interest where health professionals are included as Board members and who then bring a bias to discussions. In one case study no DHB employees are members of the Board whereas other Boards do include some employees.

### ***Board Membership and Representation***

Elected members included those with background and experience in local government, the health sector, community organisations and business. In four of the five case studies, no Māori or Pacific people were elected; in the fifth, two of the five Māori Board members were elected.

Appointed members added Māori and Pacific representation onto Boards and also were used to add business skills.

Training was organised for Board members by the Ministry of Health. Some case study Boards received continuing training from other sources.

One Board had three members resign during the term in office who were not replaced for the remainder of the term. These resignations included two Māori members.

### ***Board Performance***

As members adjusted to the role, researchers noticed there was more constructive debate and challenging of issues. Some aspects of the Board member role were found to be particularly challenging for members: the boundaries between their governance role and that of management, and between their decision-making role and that of central Government, and the sheer volume and complexity of the issues to be grasped. There was some concern about the potential disruption from having elections, given the amount of time required for a new Board to settle in.

Some case studies reported on the internal Board review processes for individual members' performance, indicating variance in the approach taken and the degree to which this is embraced by the members concerned.

Some elected members regarded themselves as representing particular constituencies, therefore perceiving there to be dual accountability. Māori Board members were reported as feeling extra responsibility to look after Māori interests and to promote understanding of these matters. One case study Board adopted a policy of collective responsibility for any decisions made which effectively prevented individual members from speaking out on any issue. This decision was controversial and also attracted negative press locally.

### ***Role of the Board and Relations with Others in the DHB***

The role of the Board was defined as ensuring the health services are run appropriately for the people of the district. Strategic leadership and strategic monitoring were seen as central to these tasks. By contrast the CEO and management are responsible for making this direction operational. Management and clinicians provide technical advice to Board as decision-maker.

In most case studies the Board meeting is the focal point for the monthly reporting and reviewing of all parts of the organisation. One case study in particular used statutory committee and strategic workshops for any strategic debate.

All case studies reported that their DHBs had made efforts to engage the clinicians. One report described managers as engaging clinicians in a collaborative, partnership role in contrast to some previous health systems. Ways of including clinicians included having clinicians on Boards; having managers with clinical backgrounds; meeting with clinicians; establishing Clinical Boards and having representation from this group attend the Board meeting; setting up a management team which includes Clinical Directors; and involving clinicians in resource allocation debates.

## ***Board Accountability***

Board members are accountable to the Minister of Health. The Crown Funding Agreement (CFA) defines the formal relationship between the Crown and each DHB. The DHB is required to report on a quarterly basis against indicators as specified in the CFA. The CFA also specifies the accountability documents which the DHB is required to produce to comply with legislative requirements: District Annual Plan, the Statement of Intent, and the District Strategic Plan.

The DAP includes plans against the indicators of DHB performance as well as performance targets. A financial incentive was set up to encourage DHBs to complete the DAP within the established time frame: those DHBs with ‘early status payment’ receive payment at the beginning of each month rather than at the end of the month, thus improving cashflow.

The SOI sets out the objectives, targets and measurable indicators towards the primary goal of ‘improving the health and well being of people’ living in that district. Audit New Zealand undertakes an annual audit of this work. One case study account of an early audit indicated the learning process for all concerned as the measuring and reporting of key performance areas was a new task for DHBs.

There was widespread criticism of the Ministry of Health’s reporting requirements. The main themes included: reporting requirements were perceived to be excessive, the lack of feedback, the opportunity costs incurred, and the failure of reporting to capture desired outcomes.

Suggested changes for the Ministry included national monitoring at a higher level and reducing reporting to a few indicator variables.

However, some informants also acknowledged the reporting was a useful starting point for the DHB’s own strategic monitoring. Some case study DHBs added their own strategic monitoring tools to enhance that provided by the prescribed key performance indicators.

## **Statutory Committees**

Under the NZPHDA each DHB is required to establish three statutory committees: the Community Public Health Advisory Committee (CPHAC), the Hospital Advisory Committee (HAC), and the Disability Support Advisory Committee (DSAC). These committees have an advisory function. In addition each DHB is free to adopt other advisory committees. In practice each of the case studies adopted a committee monitoring finance and auditing, and a range of others according to the perceived needs of that DHB.

Membership of the Statutory committees varied between case studies but in most cases consists of a mixture of Board member and community representatives chosen to complement the knowledge and experience otherwise present. The two case studies which are exceptions to this pattern both determined all Board members were also members of the statutory committees. In one of these DHBs this was an initial pragmatic decision to avoid repeated discussions. However by 2004 this decision was reviewed in favour of making the membership of each committee a few Board members in combination with community representatives. The other uses CPHAC and HAC as an opportunity for the Board to discuss strategic issues, with no external members included. DSAC follows a membership composition similar to that in other DHBs.

The division of tasks between committees varied between case study DHBs. The “solution” to meeting this statutory requirement for specific committees was different for each of the case study DHBs with differing pressure points and advantages. Some of the reservations raised included:

- the prescribed nature of the committees did not necessarily fit with the service arrangements within the DHB;
- the costs of servicing the committees was greater than the benefits they provided;
- boundary issues between the Board, the committees and managers;
- inefficiency due to double handling of issues;
- confusion over whether the committees were initiators or were to be directed by the Board.

Advantages were also attributed to the statutory committees:

- undertaking a lot of the debate and evaluation of particular issues;
- allowing a channel for the input from community representatives;
- acting as a sounding board for the Executive;
- providing further assurance to the community that their interests were being looked after; and
- promoting more independent recommendations coming through to the Board.

In most of the case studies there were ongoing processes of reviewing the statutory committees over the period of research as DHBs streamlined and adapted their committees to make them more useful for their purpose. As a generalisation, most of the case studies found the committees more useful as they evolved. In the first round of research data informants indicated concern over the costs of servicing the committees; in the second round informants were more focussed on their positive contributions.

CPHAC advises the Board on population health issues, including priority-setting, determining the strategic direction, monitoring progress on strategic goals, working on particular policies or projects, and providing a means of engaging with the public. CPHAC varied across the five case studies on dimensions of membership, tasks assigned, who sets the agenda, the level of engagement with the community, the source of information supplied, the degree of independence from the Board, the way in which it communicates to the Board and what issues the committee addresses.

The HAC advises on matters concerning hospital and specialist services. Again there was variation between case studies with the emphasis varying between operational aspects, monitoring, quality assurance, financial scrutiny, and the strategic integration with community services. Some dimensions of difference included the membership, whether managers and clinicians were included, the breadth of content and the quality of relationship between HAC and other stakeholder groups.

The DSAC was defined as advising on disability support and advocating for disabled people, implementing the Disability Strategy and raising awareness of matters pertaining to disability. In most case study DHBs the DSAC was considered to have little role until the funds for older people with disability were devolved in October 2003. Some DSACs have been more influential by taking on a wider role of advocacy and monitoring. The DSACs varied depending on whether members of disability community were included, the range of tasks covered, the level of initiative taken, whether auditing and monitoring was undertaken, and whether mental health was included or not.

## **Strategic Decision-Making**

### ***Health Needs Assessment***

The first Health Needs Assessment (HNA) was seen as an essential first step towards planning and priority-setting but was constrained by being undertaken in a very tight time frame. The three larger DHBs amongst the case studies conducted their own HNA whereas the two smaller DHBs were included in a generic process conducted by the Department of Public Health at the Wellington School of Medicine on behalf of twelve DHBs throughout the country.

The two case study DHBs using the generic process found it to be of only limited value because of the lack of local information included. Both adopted their own process in the second round, using population health data and ongoing primary care data respectively.

Of the three case study DHBs which undertook their own HNA, one undertook a “thorough survey” as a baseline for future comparison, though was limited by the lack of quality primary care data. The second described the district’s population and their use of personal health services, drawing heavily on two reports prepared already by existing community networks. The third case study DHB employed two planning analysts informed by an external reference group which included intersectoral expertise.

All the case studies reported the HNA was valued as a means of giving the evidence base to refine the broad direction set by the NZHS to reflect local needs. There was a learning process so that subsequent HNAs built on earlier processes undertaken. Whereas the first HNAs were limited to available data, all of the DHBs became more proactive in data collection to enable more relevant and meaningful assessments. There was general consensus that the HNA was valuable to guide investment decision-making and to monitor progress.

### ***The Process of Planning***

Some case studies reported tension over the numerous planning and accountability documents which the Ministry of Health required the DHBs to produce: the HNA, the SOI, the DSP, the DAP and the Crown Funding Agreement. Two case studies found the DAP in particular to be problematic, due to the tension between the compliance requirements of the Ministry compared with the strategic plans of the DHB, and difficulties specifying deliverables in a deficit funding environment.

Case studies varied to the degree in which management or the Board guided the planning process, and at what stage tangata whenua were consulted.

### ***Role of Government Strategies***

In general the NZHS was valued as providing an over-arching direction and because it was evidence based. There were no major difficulties reported from the case studies in reconciling the NZHS with locally assessed needs identified by the HNA. The PHCS was considered particularly influential and its strategic vision was widely endorsed.

### ***Constraints on Planning***

In the first round the tight time frames and the poor synchronisation of planning documents acted as constraints. Furthermore, any changes in investment were limited to marginal spending which was very limited for those DHBs with a deficit. Other constraints arose from:

- local providers lacking the capability or capacity to develop new services;
- existing contractual obligations;
- poor information on existing contracts;
- workforce shortages;
- unexpected cost increases;
- the lack of a fully operational prioritisation framework;
- Ministry of Health directives over-riding locally determined priorities;
- the time taken by the planning cycle and community consultation;
- the lack of ethnicity data;
- the ring fencing of Blueprint mental health funding (in some DHBs);
- the need for regional collaboration to resolve some service sustainability issues.

## ***Community Engagement and Consultation***

Community engagement occurred through a number of channels: having meetings open to the public and governance processes made transparent, consultation processes, reference groups for particular purposes, and by holding hui and public meetings. The term “community” was used to refer to the general public, consumers of health services or stakeholder communities such as non-DHB providers or special interest groups. Consultation and community engagement were noted to have multiple purposes: gauging public opinion, informing the public, encouraging people to take more ownership of issues, to gain input into specific issues, and empowering people to be more engaged with their health. Some of the positive gains from community engagement noted by case studies were that it was perceived to have brought the DHB and community closer together, led to increased trust by the public in the DHB, resulted in more constructive relationships with the media, increased public ownership of service changes and dealing with conflict. Some disadvantages were also voiced, including the need to manage expectations raised and the slowing of decision-making processes.

The reports on the nature of the consultation process revealed that quite different cultures prevailed in different DHBs. It seemed that the Chair of the Board was initially influential as well as the pre-existing community networks. Three case studies indicated openness to influence and cited examples where consultation has made a difference to decision-making. In the fourth DHB, there was tension from the Board about possible agenda-setting by lobbyists, despite committing resources to up-skilling all DHB personnel to make consultation a more intrinsic part of DHB processes. In the fifth case study, consultation seemed more of a token gesture.

The case study reports indicated consultation was an evolving process. One DHB educated the public what to expect of consultation, making a distinction between that as an information gathering process and the decision-making process which remained with the Board. Another DHB clarified over time their commitment to community engagement, meaning building trust and ongoing interaction, as opposed to consultation.

## ***Prioritisation***

All the case studies established a prioritisation process, usually with explicit criteria stating the desired objectives for investment or disinvestment, and usually with scope to be informed by clinicians as well as undergoing scrutiny by management funding and executive teams before presentation to the Board . In practice most of the DHBs found little scope for even marginal investment due to the domination of deficit management.. Other constraints were the need to build capacity (particularly in Māori and Pacific providers) and inadequate information or analytical capacity to undertake the task. Two DHBs were relatively advantaged by PBFF adjustments which freed up some funds for investment, and two DHBs established a small strategic investment fund to allow some, but limited development. One DHB has argued that prioritisation decisions at the DHB level can only be “within service” ones, as any “between service” decision-making should be regional or national processes.

## **Finance, Funding and Contracting**

### ***Financial Position***

Reducing their deficit dominated decision-making for all five DHBs initially. Over the period of the research, three moved to break even point, one to a surplus position, and one remained substantially in deficit. Two of the DHBs significantly benefited from the move to PBFF which corrected previous under-funding.

### ***Population Based Funding Formula (PBFF)***

PBFF was rolled out from December 2003 onwards, giving a more certain funding projection for planning purposes. The formula distributed funds proportional to the resident population, adjusted for the percentage of Māori, lower socio-economic status, rurality, the number of elderly people, and for tertiary services supplied. While the PBFF was widely accepted, some issues remained over the accuracy of the population data and the adequacy of the adjustors.

The related issue of the inter-district flow (IDF) payment system between DHBs was also perceived as attracting some risk for the DHBs concerned: for DHBs purchasing from monopolist suppliers, and for the supplying DHBs the sunk costs may not be sustained or compensated by IDFs.

### ***Deficit Management***

The DHBs have needed to manage financial risk while also attempting to reduce the deficit. Sources of financial risk included demand being higher than that contracted for; PBFF deemed to not cover aspects of cost or population growth; provider arm deficits; insufficient devolved funds; growth in services; costs not under the control of the DHBs (e.g. blood products, the exchange rate or the cost of insurance); changes in the costs of labour; and public expectations of new technologies and treatments.

Various strategies were used by the case study DHBs to reduce costs, including increasing efficiency, improving governance and management systems, scrutinising contracts, engaging with clinicians to manage demand, collaboration with other DHBs for economies of scale, repatriating services previously purchased by IDFs, and the sale of capital assets.

### ***Devolution of Contracts***

The initial devolution of contracts from the Ministry of Health and HFA occurred in June 2001. A second wave of devolution occurred in October 2003 when the funds for older people with disabilities were devolved to the DHBs. All case study DHBs reported both rounds of devolution were problematic. Each devolution was followed by a demanding process of due diligence as the DHB checked each contract for completeness, accuracy and adequacy of funding. Other problems were caused by the slow transfer or absence of contract documents, a lack of information on the management history, and the legacy of poor monitoring under previous regimes. There were widespread problems, with the second wave of devolution generally found more problematic than the first. Most of the case studies reported these processes as very challenging to the capacity of the DHB.

### ***Contracting Relationship and Negotiation***

Both DHBs and providers perceived the quality of relationship between DHB, as purchaser, and the provider as the key to successful negotiation. At least one DHB initially chose to roll over contracts to allow time to build relationships but there was tension between this objective and the providers' need for price adjustments. The DHB also needed to adapt and update contracts to population health objectives. There were mixed reports about the quality of negotiation and relationships across the case studies, although some reported improvements over the research period and that the duration of contracts has extended giving more certainty for planning purposes. Contracting conducted by SSAs, as occurred in two case studies, was seen as confusing accountability lines.

### ***Purchasing or Providing***

Two case studies reported concern amongst non-DHB providers that the DHB would favour their own provider arm in purchasing decisions. A third case study reported no observed trend towards making rather than purchasing services over the 2002-2004 research period.

### ***Form of Contracts***

The two smaller DHBs used the contract template developed by the Ministry of Health but both independently commented that the form of the contract was too rigid and too long.

Across the DHBs there was a desire to move towards shorter and more succinct contracts, greater flexibility to allow for local innovation, oriented more to outcomes, reflecting integrated care systems, and a desire to reduce transaction costs.

The lack of comment in the case studies on progress towards achieving these objectives suggests these processes are still evolving.

### ***Capital Development Costs***

This was noted as an issue of concern to non-DHB providers, particularly the smaller ones with less flexibility in their cash flow. However most DHBs regard this as incorporated into the purchase price.

### ***Lead DHB Contracts***

At the time of the DHB establishment, some of the larger DHBs acted as lead DHB, negotiating and monitoring contracts on behalf of other Boards so that the provider does not have to deal with multiple funders. Although this offered efficiency savings, this system was noted to be problematic from a number of stakeholder viewpoints at the time of the Interim Report. Since then most of these lead DHB contracts have been unbundled.

### ***Monitoring of Contracts***

Both DHB and provider informants wanted the monitoring of contracts to improve to ensure services were delivered to those who needed them and to correct perceived inequities. Efforts to improve monitoring included reviewing devolved contracts, building relationships with providers and refining reporting requirements.

### ***Devolution and Sector Relationships***

The devolution of responsibility for the purchasing and provision of the health needs of the resident district populations to the 21 DHBs is at the heart of the 2001 health reforms. The DHBs remain accountable to the Minister and central Government.

## **The DHB and Ministry of Health Relationship**

There was a consistent attitude reported in all case studies that DHBs would like more autonomy and responsibility. Local decision-making was preferred because of the greater knowledge of local needs, more timely decisions, and greater ownership of the implementation. Frustration was expressed at the continuing involvement of the Ministry in operational policy setting at the district level. It was suggested the relative roles of the DHBs and the Ministry should be clarified. With regard to the quality of relationships between DHB and Ministry personnel, the Accounts Managers consistently attracted positive comment and appreciation, whereas there were mixed reports about other relationships.

### ***Tension Points***

- Reporting requirements found to be excessive.
- The Ministry continuing to control operational policy and funding decisions at the local level.
- The DHBs not being adequately consulted over national policies.
- Difficulties created by the devolution of funds for the older disabled and by the PHCS developments.
- Some wanted public health money devolved.
- Some considered there to be a lack of leadership ensuring equitable access to specialist services, information technology and management, and resolving provider arm capacity problems.

### ***Positive Aspects of the Relationship***

- Individual Ministry personnel were generally experienced as helpful and supportive.
- Coordination between the Ministry and DHBs at national level has improved.
- State of formal documents and agreements was seen as improving.
- Interface between DHBs and the Ministry has been streamlined.

### ***What Promotes Positive Relationships***

The building of relationships by networking, regular meetings and communication protocols were noted to be helpful. Improvements to reporting requirements were also anticipated to improve relationships. There was a desire for greater clarification of the respective roles and boundaries between the Ministry and DHBs.

### ***Role of Clinicians***

Overall there was observed to greater involvement of clinicians with management than under previous models of health care. Case studies reported involving clinicians by various channels, including establishing clinical boards and by involving senior clinicians in management meetings. Participation of clinicians in prioritisation processes and engaging clinicians help to manage demand were two focal points. There were some observations that clinicians were still distant from the Board in some DHBs.

## **Devolution of Funds for Older People with Disability**

Early in the research period, the devolution of funds for older people with disabilities was widely anticipated as a positive development which would allow more flexible service provision. However in practice, the devolution on 1 October 2003 was highly problematic. Case studies reporting on the issue noted missing information, a lack of risk auditing prior to devolution, devolved provider risks, aggrieved providers due to unresolved issues, and devolved funds not covering contractual obligations. These difficulties were consistent across case studies regardless of extensive preparation in some DHBs.

Two case study DHBs expressed some concerns about the split management of funding for people with disabilities: pressure to provide for those under 65 due to lack of services in this age range and because of boundary issues arising as those near in age demonstrate needs more akin to an older age group. Those under 65 who have both health and disability needs will tend to be served by whichever service has the greater resources, rather than this being determined by what is clinically optimal. However, overall more informants considered younger people with disability should not be seen through a health mind-set and therefore there was little support for the devolution of the funds for the younger people with disabilities.

## **DHBNZ**

Over the research period, DHBNZ moved through an establishment phase to a position of providing a focal point for DHBs to coordinate information sharing and action on key issues. This was seen as promoting consistency across the sector and allowing greater connectedness between the Minister, the Ministry of Health, and DHBs. For individual DHBs, involvement in DHBNZ allows them to stay abreast of issues and to participate in working groups on topics of concern. DHBNZ also takes up issues with the Ministry on behalf of the DHBs on topics of collective interest. The reports from DHBNZ allow Board members and others to keep in touch with a wider range of issues of policy and operational significance to DHBs. However there are

some tension points for some of the case study DHBs: larger DHBs which pay higher fees and contribute more resources may be outvoted by smaller DHBs which may have quite different needs; and some Boards perceived DHBNZ decision-making as eroding their autonomy. Despite these reservations DHBNZ has become firmly established and is widely supported.

## **Capacity and Capability Issues**

The establishment of the 21 DHBs meant fragmentation of the capacity for purchasing and contract management. The DHBs have also been required to develop capacity for strategic planning, community consultation, prioritisation, contract negotiation and monitoring. The process of strategic decision-making highlighted the need for good information management systems. In addition the servicing of the Boards and statutory committees has been demanding. Accountability reporting to the Ministry has placed further demands on the capacity and capability of the DHBs. The DHBs have built up their Planning and Funding teams to meet these demands, and some collaborations between DHBs have also assisted.

Clinical workforce shortages have constrained both the provision and purchase of clinical services in some case study DHBs. Regional organisation of some services has helped to some degree but also has shortcomings.

The size of a DHB is influential for both large and small DHBs. Smaller DHBs are more dependent on collaborating with others whereas larger DHBs are not always able to safeguard their own interests.

The implementation of the Primary Health Care Strategy has added to the demands on the DHBs, stakeholder groups and on the communities served. Industrial relations have also created further pressures.

Capacity constraints have placed particular pressure on DHBs to generate more cooperative and collaborative solutions. However this requires filtering what functions are best done locally, what is best done regionally, and what should be done nationally.

## **Collaboration With Other DHBs**

All the case study DHBs collaborated with other DHBs. This was both formalised by regional and national groupings, such as through the Regional Mental Health Networks, Shared Service Agencies, and DHBNZ, and informal DHB to DHB cooperation, particularly with those DHBs with contiguous boundaries.

This included contact between DHBs over service configurations to ensure less common specialist services were made accessible to smaller DHBs; joint purchasing; pooling services such as finance and human resources; sharing patient information systems; joint negotiations on employment matters; and collaboration on IT.

Although collaboration was seen as beneficial, reservations focused on differing needs for different DHBs and the risks to autonomy.

### ***Shared Service Agencies (SSAs)***

The four SSAs are each jointly owned by the DHBs within that region. The four agencies are the South Island Shared Service Agency Limited, Central Region Technical Advisory Service, Health Share Limited Shared Service, and the Northern District Shared Service Agency. Each agency has evolved a role determined by its specialist capacity and in response to the needs of the owner DHBs.

## **Service Areas**

### ***Devolution of Primary Health Care***

There was broad support for the Primary Health Care Strategy's goals and objectives amongst case study informants. There was also optimism that the Strategy would deliver better health outcomes given time, reduce the demand for secondary services and remove barriers to access for primary care. However there were some difficulties with implementation. The Primary Health Organisations (PHOs) were seen as a vehicle for different organisations and clinical staff working together.

The process of implementation and the issues raised varied between case studies. One case study reported considerable tension over the lack of devolution of decision-making to the DHB. A second case study had positively adopted the Government's priority populations as the target for implementing the Strategy but inadvertently placed provider organisations serving these populations under severe pressure as they struggled to find the capacity to establish PHOs. A third case study allowed the momentum from the community to drive PHO development. Although this approach was successful, this district has been slower than other case studies to establish PHOs. The fourth case study established PHOs relatively early in the implementation of the PHCS. Over the research period the PHCS has been a catalyst for increased unity amongst providers, both between the disparate groups that came together to form the PHO and the trend towards increased cooperation between PHOs. The fifth case study DHB took a strongly proactive approach to forming geographically based PHOs. However the DHB has needed to give way to the preferences of providers who wanted other groupings.

Most provider informants found the DHB has been supportive and helpful. Not-for-profit community providers also welcomed PHOs because of the community focus and the integrated care approaches. For Pacific providers the model of health care is a holistic one which often involves support to the whole family. However this is not easily recognised in the funding model which is just based on population.

PHO responsiveness to Māori varied, with some PHOs showing awareness of the need to be more responsive and to engage in consultation. It was hoped that as relationships deepened between PHOs and Māori providers there would be better understanding of ways to improve Māori health.

By the end of the research period the PHCS was still bedding in but was noted to be the focus of most of the new investment, was resulting in greater integration between primary and secondary services, and collaboration between providers who previously had worked competitively. Inter-sectoral work to achieve population health objectives was at a much earlier stage of development.

### ***Public Health***

There were some mixed views whether the funding for public health services should be devolved to DHBs. However most informants across all case studies were impatient for this to occur. Some favoured allowing the changes to bed in before taking on additional responsibilities. Those in favour saw the need for consistency of allocation of responsibility across the health sector and because of the emphasis on population health in the 2001 health reforms model. Those against emphasised the need for national consistency and retaining a critical mass of public health expertise in a single organisational setting.

### ***Mental Health Sector***

The case study reports highlighted a range of issues which varied across the case studies. Mental health specialist service delivery depended on regional cooperation but there was tension around aspects of the Regional Mental Health Networks and regional decision-making. Other issues were that ring fenced funding was perceived as too restrictive, given the recruitment constraints; the variation in accountability systems used in different DHBs and for different providers; regional access to specialist services was not always satisfactory; and workforce and capacity shortages.

## ***Rural Sector***

Rural health was an issue for at least two of the case studies. Although the PBFF makes an allowance for rurality, the adequacy of this was questioned because of poor economies of scale and workforce issues.

## ***Secondary Services***

One case study identified “the substantial discrepancy between contracted volumes for services and actual demand” as a pressing issue.

## **The DHB Model**

### ***Comparison with Previous Models of Health Care Delivery***

The DHB model was compared favourably with previous models across all the five case studies because of the focus on population health and health promotion, the involvement of the community, the greater integration between services, the emphasis on collaboration, the scope for flexibility and innovation, and local decision-making. Some tension was noted over the DHBs carrying the political risk for Government, balancing local responsiveness and national consistency, and reporting requirements.

A number of Māori and Pacific respondents preferred the HFA model. Māori informants preferred the single purchaser because there was only a single point of contact, a clearer focus on and commitment to the Treaty, and there had been a critical mass of expertise in the field of Māori health. Others who preferred the HFA model perceived it to be more efficient.

Most informants did not support the RHA, CHE or AHB models.

### ***Strengths of the DHB Reforms***

The strengths of the reforms identified by respondents were noted to be:

- the goals of the reforms;
- the holistic approach to health;
- the reference to the Treaty in the NZPHD Act;
- governance structures;
- community involvement in strategic decision-making;
- the more transparent culture;
- the integrated district wide approach for maximum gains;
- the transparency of decision-making and local monitoring;
- the emphasis on cooperation, collaboration and working in partnership;
- innovation;
- the national health strategies;
- health strategies providing leadership and national direction; and
- the primary health care strategy.

The weaknesses of the DHB reforms identified by respondents were noted to be:

- the numbers of DHBs;
- the degree to which decision-making stayed with central Government;
- instability created by having elected Board members;
- excessive reporting requirements;
- perceived inadequacy of funding;
- too many strategies and initiatives;
- lack of data for decision-making;
- loss of contestability of purchasing decisions, according to non-DHB provider informants;
- complex bureaucratic structure;
- increased costs arising from the greater transparency and accountability;
- Pākeha domination: the DHB model is ‘a Pākeha model’ driven by middle class white people;
- implementation issues with the PHCS;
- inadequate addressing of inter-sectoral issues;

- continuing workforce constraints, accentuated by the fragmentation of the critical mass of skills under the HFA model; and
- multiple levels of decision-making for some services.

### ***Potential Improvements to the Model***

Informants suggested a number of changes to improve the model.

With regard to the reforms overall:

- no further change, to allow these reforms to “bed in”;
- reducing the numbers of DHBs; and
- having just a few key strategies.

With regard to Board members:

- more appointments to Boards to ensure the right mix of skills; and
- better training for Board members.

With regard to consultation:

- more regular consultation channels.

With regard to management:

- better management training.

With regard to funding:

- regionalise the funding functions;
- more transparency about funding decisions; and
- improve alignment between services provided and funding.

With regard to providers:

- more partnership with providers; and
- greater certainty for providers to facilitate longer term planning.

With regard to the role of the Ministry:

- clarification of the role of the Ministry;
- more autonomy to the DHBs;
- refining reporting requirements so DHBs report more on outcomes;
- make the Statutory Committees less prescriptive; and
- publish documents around health delivery in Māori as well as in English to improve Māori health.

With regard to collaboration:

- DHBNZ taking a greater role on some DHBs' operational functions would reduce costs and overcome capacity constraints.

With regard to integration:

- integrate strategic planning between DHBs and local Government;
- align at every level between the Ministry, the DHBs, and the non-Government sector to achieve some real culture change; and
- integrate provider services in the community to a greater degree.

With regard to primary care:

- match the annual planning cycles of PHOs and DHBs; and
- make more use of the primary care infrastructure that is starting to emerge through PHOs.

With regard to public health:

- enable DHBs to be totally responsible for the health needs of their community by the devolution of public health fund; and
- hold a regular public health care forum to stimulate public interest in key issues.

With regard to other sectors:

- fund and manage tertiary services separately, outside of the DHB model;
- hold round table discussions for all involved in mental health; and
- DHBNZ to take on a greater role as a means of reducing costs and overcoming capacity constraints in DHBs.

## Implications

The evaluative judgements throughout the report reflect the various criteria which apply: equity, efficiency, engagement of the community, integration of services, responsiveness to Māori and other marginalised groups, and the achievement of larger population health goals. There is a dynamic tension between some goals: national equity and consistency and versus local responsiveness; local decision-making versus Government leadership; local decision-making versus more efficient economies of scale; accountability through reporting requirements versus flexible and innovative systems based on trust; and looking after local interests versus ensuring services for the region.

The DHBs have developed skills to look after their resident populations. This has included developing collaborations. It is expected that DHBs will continue to filter out optimal levels of organisation for different tasks and functions, for efficiency and to overcome capacity constraints. There is a risk that too much rigidity in reporting requirements and central Government direction may constrain emergent innovation.

The research findings largely speak for themselves. However some questions are raised. With regard to governance, the impact of the culture of the Board, conflicts of interest, the length of the electoral term, whether the statutory committees should be reviewed, and the role of management in relation to the Board are aspects that are queried. With regard to strategic decision-making, the optimal role of community engagement, the data to support health needs assessments, and the conditions to enable prioritisation are queried. With regard to finance, purchasing and contracting, accountabilities for deficit, the impacts of having a deficit, and safeguards for non-DHB providers are commented on. With regard to devolution and sector relationships, reporting requirements and the role of clinicians are commented on.

## **Acknowledgements**

The case study reports were authored by: Pauline Barnett, Clare Clayden, Marie Russell, Toni Ashton, Tim Tenbenschel, Tai Walker, Amohia Boulton, Sue Buckley, Anne Goodhead.

The research team gratefully acknowledges the funders who have made this project possible. The project was funded jointly by the Health Research Council and Ministry of Research, Science, and Technology through the Departmental Contestable Research Pool managed by the Ministry of Health, the Treasury and the State Services Commission.

The Research Team warmly acknowledges the support of Board members, DHB staff, providers and stakeholders who have contributed to the various case studies. We thank all those who so willingly shared their knowledge and opinions with us. We also thank those DHB staff in the case study DHBs who provided additional materials and information when requested.

Each of the case studies was put together with the assistance of a team of researchers. Although the main researchers are listed as authors, their efforts were enabled by the wider research team.

## Abbreviations

AHB	Area Health Board
CHE	Crown Health Enterprise
CEO	Chief Executive Officer
CFA	Crown Funding Agreement
CPHAC	Community and Public Health Advisory Committee
DAP	District Annual Plan
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DSAC	Disability Support Advisory Committee
DSP	District Strategic Plan
DSS	Disability Support Services
GMS	General Medical Subsidy
GP	General Practitioner
HAC	Hospital Advisory Committee
HFA	Health Funding Authority
HNA	Health Needs Assessment
HOPS	Health of Older People Strategy
IDF	Inter-District Flow
MoH	Ministry of Health
PBFF	Population Based funding formula
PHCS	Primary Health Care Strategy
PHO	Primary Health Organisation
NZPHDA	New Zealand Public Health and Disability Act, 2000
NZHS	New Zealand Health Strategy
PHCS	Primary Health Care Strategy
PHDAP	Pacific Health and Disability Action Plan
RHA	Regional Health Authority
RMHN	Regional Mental Health Network
SCS	Service Coverage Schedule
SMT	Strategic Monitoring Tool
SOI	Statement of Intent

SSA	Shared Service Agency
SSP	Statement of Service Performance
THA	Transitional Health Authority

# 1 Introduction

## 1.1 Background to the Project

The Health Reforms 2001 Research Project was undertaken to chart the progress of, and evaluate, the health reforms enacted by the New Zealand Public Health and Disability Act 2000 as they were implemented. The objective of the research was to document, comment on, and assess the strengths and weaknesses of alternative ways of organising the strategic decision-making, governance, purchasing and accountability arrangements which develop under the Act. The project was funded jointly by the Health Research Council and by the Ministry of Health, Treasury and the State Services Commission, who co-funded the research through the Ministry of Research, Science and Technology Departmental Contestable Research Pool. The Health Services Research Centre, Victoria University has managed the project with a team of independent researchers.

The research has taken place over four years (2002-2005) and included both a national overview and five local district health board (DHB) case studies. The local case studies were intended to provide additional detail and local insights to complement the more general national overview.

## 1.2 Overall Methodology

The full research project has taken place over four years (2002-2005) and has four streams:

*Stream 1:* Collation of the expectations and experiences of the reformed system. Data sources include document analysis; key informant interviews with ministers, officials and others; a postal survey of all Board members; and interviews with all DHB Chief Executive Officers (CEOs), Chairs, and Planning and Funding Managers.

*Stream 2:* An examination of five case study DHBs in greater depth.

*Stream 3:* Documentation of the policy context in which the reforms are embedded.

*Stream 4:* A comparison of this model with the previous models of health system organisation in New Zealand.

The five case studies on selected DHBs were intended to provide additional detail and local insights to complement the more general national overview. This report collates those five case study reports to give an overview of the implementation of the NZPHDA model in practice.

### **1.3 Research Methods**

The research was set in a formative and process evaluation framework, reflecting the government's intention to alter the way that the health sector performs its work and the recognition that it is not possible to assess health and economic outcomes of the reforms within a three- or four-year project.

The research contract required tracking the implementation of the reforms over time, and as such, it was crucial to capture experiences and challenges as they occurred. The data on which the case study reports were based were collected primarily in two periods: the first from mid-2002 and into 2003, and the second during 2004 through to early 2005.

The research plan was reviewed by the Wellington Regional Ethics Committee, which judged that ethical approval was not required. The project adhered to sound ethical research practice, including the need for written consent from those to be interviewed, and right of withdrawal at any time.

Five DHBs were selected to reflect a range of size and demographic features. Two large DHBs were included, two medium size and one small DHB. Further information about the DHBs in the sample is given below.

The case study research drew on three main sources of data within each of the case study DHBs:

- **Documents** used included meeting agendas, minutes and reports to the Board, District strategic and annual plans, statements of intent and crown funding agreements and other publicly-available materials.
- **Interviews** with DHB members, senior staff, providers and stakeholders such as Ministry of Health staff. Interviews were semi-structured and based on a national template, but adapted for local use. Interviews were transcribed and checked by those participants who wished to do so prior to analysis. Direct quotations from informants in this report are given in italics.
- **Observation of Board meetings.** Researchers attended at least four Board meetings in each of the case studies (public section) and recorded using research tools adapted from Peck (1995). This approach consists of a narrative, a record of the contributions of individual Board members and an overall assessment of Board response to individual agenda items.

The analytical framework was developed from the main themes and sub-themes of the research. The interviews were coded using NVivo software to sort the material for relevance to the research themes of interest, with new themes also identified from the data. Analysis included reviewing material from multiple sources to confirm and interpret the way in which events unfolded and issues were managed.

#### **1.4 Characteristics of the DHBs**

The case study DHBs were chosen to reflect a range of size and demographic features. Two large DHBs, two medium size and one small DHB were included. The populations ranged from 44,000 to 430,000. Two case studies were predominantly urban, two a mixture of urban and rural, and one had a significant rural population (30% rural population compared to the national average of 15%).

The population mix also varied between the five case studies. The proportion of the population who were Māori ranged from 6.8% to 44%. Those who were Pacific ranged from 7.6% to 1.6%. Asians accounted for 1% to 9.4%. Europeans ranged from 48.5% to 84%.

Other features are relevant to the DHBs in relation to their decision-making: geographical spread, socio-economic status, the extent to which the population is youthful versus ageing, whether the population is predicted to grow or decline, and the health status of the population. In one case study DHB only 32% of the region's roads are tar sealed, compared to the 57% national average. The five case studies varied on all of these dimensions.

## **1.5 Caveats to the Report**

This report draws on the five individual case study reports to take an overview , noting common themes and points of difference. This report is based entirely on the case study reports and therefore does not draw directly on the interview material or DHB documents.

The Māori and Pacific sub-sections of the case study reports have been reported on through the Māori and Pacific theme reports respectively so have not been included in this report.

Although the interview schedules for different roles were common to the five case studies, there was some adaptation to local circumstances. Furthermore, informants' viewpoints inevitably reflected the particular concerns and issues of that DHB. Therefore not all reports commented on all issues and inevitably the prominence given to particular issues varied across the reports. The purpose of this report is to document the implementation of the DHB model in practice. This variation between case studies is drawn on to illustrate the type of adaptations to local circumstances employed across the case studies.

Throughout the research planning and reporting the research themes have been related to the relevant clauses in the NZPHDA. This Act has since been amended to reflect the Crown Entities Act 2004, passed in December 2004. As the period of research occurred prior to these amendments, the reporting here in most instances reflects the original NZPHD Act.

## **1.6 Form of the Report**

This report collates the five case study reports, drawing out the themes, similarities and differences between the five DHBs concerned on the research topics of interest:

- Governance
- Strategic decision-making
- Finance, funding and contracting
- Devolution and sector relationships
- Reflections on the DHB model.

Any reference to individual case studies is done in such a way to preserve anonymity to the DHB concerned. This has been done for a number of reasons: to respect the wishes of some of the DHBs concerned; to avoid any one informant from being identifiable; and because the subject of interest is the generic implementation of the 2001 health reforms, rather than implementation in any particular DHB.

However, given there are some consistent themes of difference between the individual DHBs, each of the five is referred to in a constant way, such as case study A, case study B, and so on. This will allow the interested reader to follow through themes of interest. For example, the culture of the board may be compared to the information on the number of members of public attending or the consultation processes for that individual Board. However it is intended that the actual identity of that Board is withheld because the topic of interest is the NZPHDA model and the implementation of that model, not the performance of the DHB.

Where a case study report has been quoted, quotation marks have been used, for example:

“During 2002 and 2003 the Board met every six weeks, but the frequency of meetings increased to monthly during 2004. We note that this change has resulted in a more measured and better-managed agenda, with issues generally being followed up in a timely manner.”

In this instance, the “we” refers to the researchers.

Where direct quotes from informants are used this is indicated by speech marks and italicised text, for example this statement from a case study informant talking about the deficit in that DHB:

*“It’s sort of like the elephant in the middle of the living room really, sometimes we manage to step around it but it’s just there hugely.”*

In most cases, the past tense is used as it refers to the findings as observed throughout the research process which are now in the past. This should not be taken to imply that this status does not apply now. By contrast, the quotes (from informants and within the individual case study reports) often state the situation to be in the present, and that format has been honoured here. However, it should be recognised that the same caveat applies: the status quo as referred to then may, or may not apply now.

## **2 Governance**

### **2.1 Legislative Framework**

Governance is the function that ‘holds management and the organisation accountable...and helps provide management with overall strategic direction’ (Shortell and Kaluzny 1993).

The New Zealand Public Health and Disability Act 2000 (NZPHDA) made far-reaching changes in the health system. It set up 21 District Health Boards, and prescribed their role and activities. The Minister of Health provided the framework for the Government’s overall direction of the health sector (NZPHDA s.8).

Under the legislation, the District Health Boards (DHBs) are:

- charged with improving, promoting, and protecting the health of people and communities in their districts; and
- accountable to the Minister of Health through prescribed mechanisms, including development of District Strategic Plans, District Annual Plans and other processes;

The overall strategy is determined by the government (s.8). DHBs were established as statutory corporations under the NZPHDA, now amended (NZPHDA Part 3 s 21) to crown entities under the Crown Entities Act 2004 s7. The DHBs are charged with achieving strategic goals related to improving health and independence in the community, the provision of services and fostering community participation in health improvement and service planning. DHBs are accountable to the Minister of Health (NZPHDA Part 3 s. 37) and 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 be consistent with, the New Zealand Health Strategy (NZHS) and the New Zealand Disability Strategy (NZDS) (s.38 (7)). Under the NZPHDA s 10(1) the Crown Funding Agreement (CFA) refers to the agreement of the Crown to provide funding in return for the services specified in the agreement. The

CFA also entitles the Crown to monitor performance (s.10(2c)). Monitoring is delegated to the Ministry of Health (s.10(3)).

Each DHB governing Board is to consist of seven elected members and an additional four members to be appointed by the Minister of Health (NZPHDA Part 3 s.29). There must be at least two Māori members on each Board. Conflicts of interest must be declared prior to election. Employees of the Board are eligible for election. The NZPHDA Part 3 s.34, 35, and 36 directs DHBs to establish three statutory committees to provide advice to the governing Board: the community and public health advisory committee (CPHAC), the disability support advisory committee (DSAC), and the hospital advisory committee (HAC). The Boards must provide Māori representation onto these committees.

DHBs must ensure a community voice in matters relating to health and disability support services: through having elected members of Boards, by the Board and certain Committee meetings being open to the public, and through consultation on strategic planning (NZPHDA Part 1 s.3(1)(c)).

The NZPHDA Part 3 s23(1) specifies a number of functions for the DHB to fulfil, including ensuring the provision of services for its resident population; actively investigating, facilitating, sponsoring, and developing co-operative and collaborative arrangements with persons in the health and disability sector; promoting the health of people; issuing relevant information to enable Māori to participate in, and contribute, to strategies for Māori health improvement; and fostering Māori capacity in the health and disability sector.

## **2.2 Board Processes and Procedures**

### **2.2.1 Meetings**

Under the NZPHDA the Boards are required to fulfil a number of functions. The Board meetings are the forum in which these activities and objectives are addressed. In one Board (A IR:10) the meetings “are a forum for discussion and decision-making and also for interacting with the [district] community”. In another case study the function of the Board (C IR:6) was described as setting and monitoring the strategic direction of the DHB.

In all but one of the case studies, the Board meetings have been held monthly. One Board (case study C:7) met at six week intervals throughout 2002 and 2003, then changed to monthly meetings for 2004. The researchers observed that, as a result of this shift to more frequent meetings, there was a “more measured and better managed agenda, with issues generally being followed up in a timely manner.” Although the number of agenda items did not reduce, the researchers concluded issues were followed through more efficiently.

The timing of the statutory advisory meetings relative to the Board meetings varied, for example one case study Board (B:15) held the advisory meetings one to two weeks before the Board meeting so that those meetings feed into the Board meeting whereas another case study Board (D:13) held the committee meetings in the morning, followed by the Board meeting in the afternoon.

Some Boards routinely held “public excluded” sessions. In one Board (B:15), until August 2003 the public session was held first, followed by the “public excluded” section. This order was reversed after that date to allow those items deemed which could be drawn into the public section to do so the same day, rather than being delayed a month. In another Board (C IR:7) there is a closed workshop after most Board meetings which is “characterised as a venue for educating Board members and management, and a forum for debating and discussing sensitive issues.” Although this workshop setting is explicitly not a decision-making forum, the agenda covers matters

of substantial importance to the Board, including routine updates from the Chair and CEO; reports on financial matters; legal and risk updates; and early stage discussion of strategic issues, plans and policy developments.

Two of the five case study Boards (A:IR10 and D:13) rotated the location of some of the meetings around the district to make them accessible to the public, and one Board (A IR:10) added in a public forum prior to the formal Board meeting to allow the public to ask questions about health and disability services at a local level. It was noted these forums are held in various towns around the district and have been well attended. It is noteworthy that these two Boards both have a culture of accessibility to the public and that the policy of taking the meeting to the people can be seen as another way this is implemented. A third Board (E:15) started by rotating through the district but then settled into one location “for convenience reasons,” suggesting a higher priority was placed on the efficiency of time for the Board and management participants than the objective of being accessible to the public.

### **2.2.2 Culture of the Boards**

The culture of the five Boards was found to vary considerably.

In one case study Board (E:15) informants stated *‘the Board is very, very keen’* and *‘the Board works well together.’* A second Board (A:IR 11) was described as having a style of informality, *‘very relaxed,’* some light banter, and high cooperation between Board and management. A third (case study D:13-14) was characterised by informality and inclusiveness with no formal demarcation between members and the public with regard to the seating arrangements. In this Board, all who have something to contribute are encouraged to speak, and staff and members were observed to listen to each other with respect.

A fourth Board's (C:8) setting was described as having a "gloomy ambience, formal and distant seating, poor acoustics and lack of intimacy." The Chair sat on a raised dais at one end of a formal U shaped seating arrangement, flanked on either side by the CEO and kaumātua, and other Board member and management participants seated in a formal manner. The meetings of this Board strictly adhered to standing orders. Interestingly, while the usual venue was being refurbished, the meetings were transferred to a less formal setting which was observed by the researchers as conducive to less formal meeting dynamics and closer interactions between participants.

Only one of the five case study Boards (case study B:18-19) was observed as sometimes tense and conflictual, with researchers noting some instances of disrespectful behaviour, interrupting others, and talking while others are speaking during meetings. Some non-Board member informants described this Board as dysfunctional. However the researchers also described (B:15-16) the meetings as "informal", both by observation and the fact that the Board's protocol "Behaviour at Board and Committee meetings" emphasised informality. Visitors were supplied with meeting documents and warmly welcomed to join Board members and DHB staff for refreshments.

The Chair was found to be particularly influential in setting the style of the Board. Two reports stated the Chair was responsible for keeping the agenda moving forward in order to complete it in the allocated time (A:IR 11 and C:8) . The facilitative role of the Chair was described (A IR:11):

*"The approach of the Chair appears to be to facilitate discussion, to summarise key points and to ensure that there was both consensus on the decisions made and that all who had participated in the discussion were happy with the decisions."*

Another Chair was described (D:14) as having a personal style of being frank and forthright but also as being very inclusive. The researchers considered this set the tone of the Board's deliberations.

A common theme amongst the case studies was the steep learning curve that members moved through as they deepened their understanding of the sector, their role and accountabilities within it, and how to work together as a team. Over time most Boards became less factionalised and more cohesive as they strived to advance the bigger perspective that Government policies are trying to achieve. For example, one Board (E:16) which had a relatively high number of elected health professionals was initially more factionalised as these members pursued their particular interests. Over the duration of the electoral term the researchers noted the Board became more focussed on district-wide strategic issues.

Governance under the DHB model was contrasted with that under previous systems which were described as having corporate boards concerned with financial performance. The DHB Board (E:15-16) was described by one Board member as a hybrid between the corporate board and a public board which is representative of community interests. The researchers observed this to reflect a shift from a corporate, business model of governance to a more community based, political model of governance where substantive issues of community concern have much greater presence.

### **2.2.3 Agenda**

Various processes are used to set the agenda. In one case study Board (A IR:10), the agenda is set in line with the annual work programme and reporting framework established by the Board for itself and for each committee, but updated and revised monthly. In a second case study Board (B:16), the agenda is set by the Chair and CEO together, and they also determine which items are to be “public-excluded”. In this Board items are organised under standard headings: strategic issues, monitoring and performance (including the CEO’s report), accountability requirements, improving business, advisory committee reports, and general business. In a third Board (C:IR 16), the agenda is worked out by the CEO, principal administration officer and committee secretary. Board members can also apply to have things added to the agenda via the Chair. Case study E (E:23) reported the Chair has the final decision on what goes onto the agenda, although in discussion with the CEO.

Most of the case study Boards have a number of standing items in addition to discretionary items. Standing items include the conflicts of interest register, CEO update, financial reports, updates from statutory committees, and updates from DHBNZ.

Two case studies noted members struggled with the volume of papers to prepare for meetings. In one case study Board (A:11) some members commented on the “enormous amount of reading” required to prepare for Board meetings. One informant suggested speed reading should be included in the initial training for Board members. Another case study Board (B:16) attempted to sift out the “information only” reports to reduce the pressure on Board meeting time. At the end of the research period, members of this Board were receiving between nine and sixteen information papers per meeting.

One case study (B:17-18) reported difficulties over the boundaries between the Board, the Executive and the Statutory committees, with the Chair making efforts to determine the relationship between these parts of the organisation. In July 2002 the Chair outlined procedural protocols to spell out more clearly that the Board retains the decision-making function: “[The] Board is where the decisions are made because this is where the responsibility and accountability lies.” The Board was identified as the group which sets the work programme according to the District Strategic Plan, and directs the Advisory Committees as to their work programme. The statutory committees were deemed advisory to the Board and were warned against developing their own programme. Furthermore, Board members who are also committee members were advised to act as Board members when attending Board meetings and therefore should consider issues from broad perspectives, rather than from the advisory committee perspective (B:17-18). The researchers observed these issues continued to challenge Board and committee members throughout the research period, and in fact, a dispute over “appropriate access to information” led to the resignation of the CPHAC chair in 2004.

Other case studies did not report on the boundary between Board and statutory committee meetings, suggesting it was not an issue.

## 2.2.4 Transparency

In all case studies the Board and committee meetings were noted to be open to the public, as required by legislation. All advertised their meetings in the press, and most made agendas and minutes available on the website. Other documents pertaining to the business of the Board were also posted on the DHBs' websites.

All the case studies reported that Boards reserve some of their agenda to public-excluded sessions. These sessions contain those issues deemed to be sensitive including contract negotiations, service contracts, sales offers, complaints, personnel matters, and issues of individual privacy. However there was found to be considerable variation between the case studies in the reported level of comfort with transparency and in the Boards' use of closed sessions.

One case study Board (D:14) embraced transparency from the beginning. Informants widely attributed the culture of openness to the Chair of the time. *"The Chair was a breath of fresh air- he thumped the table and said: 'I want transparency, I want action.'* "Over twelve months of document collection, the researchers noted there were only two brief episodes of closed meetings. One of these sessions was to review Standing Orders, including the processes to deal with issues raised by the public, and the other was not specified. The transparency was strongly approved of by research informants who perceived it as promoting public awareness and involvement. Informants associated open meetings with quality debates. Members of the public were encouraged to contribute to discussions in both Board and committee meetings. No problems were recorded as arising from the transparency.

A second Board rapidly moved to minimal use of closed session (A:15), as expressed by this informant who stated:

*"we started off actually being a bit nervous about discussing a whole lot of things in the open forum. But ... within a year we realised that there was actually a whole heap of advantages in keeping as many things out of [closed sessions] as we possibly can."*

This Board (A IR:10 and A:15) conducted an estimated 20% of its business in closed sessions in the first round, whereas this had dropped to an estimated 5-10% by the second round. In each case the Board secretary ensures the item meets the Standing Order paper's rules justifying the non-transparency.

A third case study report (B:20) spoke of the Board "becoming more courageous about being open." Within this Board, in late 2002, there were "several challenges by Board members to the balance of items across the public/ public-excluded agenda" resulting in some items being moved to the open section. Two informants in this Board considered the determining principle to be that if the item was deemed likely to embarrass the Minister, then it was likely to be placed in the public-excluded section of the meeting. This Board (B:15) initially held the public meeting before the closed session, but in August 2003 changed the order to allow some items dealt with in private to then be moved directly into the open meeting.

By contrast, case studies C and E continued throughout the research period to use closed workshops to discuss sensitive matters and to debate strategic policy.

Case study C (C:IR 8-9) reported Board members' initial anxieties about openness were resolved by adopting a policy of routinely holding closed workshops after every Board meeting to discuss sensitive matters. Although the Board meetings were open to the public, no controversial topics were discussed within these open meetings. The closed meeting was deemed for information and discussion purposes only, but the more sensitive and strategic issues were debated in this forum. It was also used to educate Board members and management. The first round of research found a range of views. Some informants had relaxed to a recognition that there was little that could not be taken to public meetings. Other informants remained cautious about discussing sensitive matters in public and considered having meetings open to the public did not add much. One informant thought the '*shrouded public meetings*' should stop, as that is not where '*the real work is done.*'

After the second round of interviews, the researchers concluded (C:9) that “on balance, there seemed to be a consensus that having public Board meetings is probably both beneficial and helpful.” Transparency was regarded as necessary because it is public money that is being spent. However some informants in this DHB continued to hold a lingering attitude that the presence of the public was inhibiting to full debate, and therefore having both open sessions and closed workshops for all the Board and committee meetings was seen as the solution. Some informants held the view that opening up the Board meetings had transferred political pressure from the Government to the DHB. Other informants challenged the secrecy, maintaining closed doors created suspicion.

A fifth case study Board (E:19 and E:23) routinely held a 20 minute “Board only” session prior to the main meeting starting, to plan their approach and to warm-up members to participate in the discussions. Within this Board the main debates occurred within the CPHAC and HAC statutory committees, which all Board members were also members of, and in strategic workshops. The Board meeting was only used for formal decision-making, as described by one Board member:

*“We try to keep the board meeting pretty much for decision, you know decisions that have been perhaps thrashed out if you like at committee level and recommendations that come to the board for basically sign-off or any final bits and pieces that need to be discussed.”*

It is noteworthy that few members of the public attended these Board meetings, with the exception of one member of the public who always attended committee meetings to the extent that she is regarded as de facto member. One Board member expressed surprise and disappointment in the lack of public attending the Board meetings.

### **2.2. 5 Public Attendance at Board meetings**

Within the five case studies, there is a range of policy with regard to visitors participating in Board meetings. One Board (D:15) routinely heard whatever any interested party had to say; another Board (A:15) used standing orders to allow public comment wherever possible; while a third Board (C IR:9 ) used standing orders “to

pick and choose” public comment (e.g. the researchers observed a Māori spokesperson was allowed to speak but a union delegate was disallowed to speak); and two Boards did not allow public comment. Most reports spoke of the pressure of time to get through large agendas which undoubtedly acted as a constraint, even if the willingness to involve the public was present.

Most case studies observed few visitors to Board meetings. For example, public attendance was described as “minimal”(C IR:8 and C:9) at one Board, while a Board member informant on another case study (E:23) expressed disappointment at the lack of public attendance.

However the two Boards which gave more scope for public input were also the two that attracted more visitors. One case study reported (A IR:13) that a modest number of visitors attended, “typically numbering up to five.” In the same case study, two public forums were observed to attract about 60 people on both occasions. During the six month period covered by the second round of research, minutes of Board meetings indicated (A:15) an average ten visitors attended each Board meeting. This Board has a policy of accommodating all requests for public comment on agenda items wherever possible, within the constraints of content and time. Case study D (D:14), which was noted above as having a strong culture of openness, also has some stakeholders who regularly attend.

The Boards with few visitors suggested various reasons for this: a room which is too formal and not inviting, and conversely, Board members welcoming visitors warmly which removes anonymity to those visitors who prefer that; the lack of discussion of controversial matters; the Board meetings “*are not where the real work occurs*”; as a society we are not very participatory but instead rely on the media to keep us informed; and the history of previous health reforms has served to dis-empower people so that now the public are not strongly engaged in health governance.

### **2.2.6 Benefits of Transparency**

Informants perceived the benefits of transparency to be greater than any perceived disadvantages. The following benefits were noted:

- *‘The only way to have significant public awareness, knowledge and acceptance.’*
- *‘That is where the really good debate occurs,’* referring to active involvement of public and stakeholders.
- The culture of transparency extends to the existing contracts, and the openness is helpful to accountability.
- Having elected Boards has moved health back into the public domain.
- Because the Board is spending public money, it should be accountable.
- Open meetings are helpful in managing the community’s expectations and allowing a more positive relationship with the press.

### **2.2.7 Disadvantages of Transparency**

Most of the disadvantages raised suggested that open and transparent meetings were likely to inhibit debate, because of the disinclination *‘to air your dirty laundry in public’*, and because Board members may be more forthright without the public and the media observing. However, those Boards that were initially inhibited were observed to become more relaxed over the period of study, suggesting this was a perceived constraint which participants were able to transcend over time. A related issue was the concern the media would report negatively. A third “rule of thumb” was cited as anything that is likely to embarrass the Minister should be in the public-excluded category. Another view expressed was that the Board debate should neither build unreasonable expectations in the public, nor pre-empt the Minister’s decision-making.

### **2.2.8 Media Reporting**

The case study research indicated the media were not strongly engaged with reporting the Boards' activities, although this varied between case studies.

One case study (A IR:13) noted that representatives of the media usually attended Board meetings and would report proceedings the following day. Informants in this case study approved of the policy of transparency because it promoted positive relationship with the media.

Another case study (B:20) found "very little media interest in the Board meetings, or in community consultation." However the local press did report on controversial topics, such as the debate over the site of a new facility (B:14). Overall though the researchers concluded (B:34) there was a general absence of public and media interest which contrasted with the "community participation" intentions of the NZPHDA.

A third case study (C:9-10) found that "much of the media reporting arising from public Board and Committee meetings has been negative." The media tended to report on two themes: the performance of the Board in key areas of public interest such as waiting lists and deficit management; and the ruling that Board members should not speak out individually on some matters, referred to as "gagging." This Board (C IR:13) has adopted a policy of collective accountability which means that individual Board members are forbidden to make public statements. This media policy has been strongly challenged by some Board members on legal and political grounds. Although the challenge was defeated, the debate on this issue was widely reported. The forthcoming election of Board members also stimulated increased reporting. An example from the same case study illustrated the difficulties that can be caused by negative reporting. One HAC member criticised a manager within the public section of the meeting, subsequently reported in the press as a "vicious attack." This reporting was deemed damaging and undermining of Board-management relations, and disempowered the HAC from holding management accountable in a constructive way.

In a fourth case study (D:14) the press was noted to occasionally report a statement from the Chair or CEO, or “a very loud Board member.” A local press representative, interviewed as part of the research, observed (D:106) there had been fewer letters of complaint since the DHBs were established.

In the fifth case study, researchers did not report media representatives as attending Board meetings but a Ministry of Health informant complained (E:55) the DHB or Board showed a “*willingness to hit the media*” rather than directing issues to the Ministry.

### **2.2.9 Conflicts of Interest**

The NZPHDA requires Boards to declare conflicts of interest and gives a protocol for dealing with this in Schedule 4, Clause 38 of the Act. A conflict of interest is defined as existing when material benefits may flow to Board (or Committee) members from the decisions the Board makes. Members are required under the Act to declare the existence of a conflict of interest as soon as they become aware of it, and that these declarations are to be kept in a register. The Board has discretion whether or not to allow that member to partake in the discussion but must exclude them from decision-making on that issue.

All case studies reported that Boards (and Committees) kept a “conflicts of interest” register. This was regularly included as an agenda item on some Boards while other Boards required a written declaration. Some informants across case studies commented Boards were readily able to identify conflicts of interest because the culture of transparency meant the background of individual members was known.

Only one case study (E:23-24) found conflicts of interests initially problematic. Although the four elected local health professionals abstained from voting on some matters, some informants considered they were likely to introduce a general bias into debate. For example, Board members who were also health professionals from the primary care sector were more likely to argue for funding directed to that end of the spectrum of care, thus introducing a bias which may have wide impact on the rest of

the Board's operations. One informant stated (E:15) "*there are problems with people who pursue their interest for their particular issue when that is not necessarily in the overall design of what the Board is wanting to do*". This case study Board used a review process between the Chair and individual members to raise awareness of aspects of the role, including potential conflicts of interest. This was overcome in time however, as the second round of interviews (E:16) indicated Board members were able to see the larger perspective of government's policies and objectives rather than any partisan approaches.

Another Board (D:16) conveyed a different attitude, as partisan interests were freely acknowledged and accepted. Those who commented on it did not find Board members' partisan views a problem, but instead to be expected. One even stated this was a strength as they are "*a more powerful advocate when seated at the table.*" From this viewpoint the lack of "lobbyists" for the alternatives, rather than the existing representation, was seen to be more problematic.

However, at least one informant from this Board considered DHB-employees on the Board would be a problem. Other Boards have included employees; one Board (B:28) has developed protocols specifically to deal with this.

### **2.3 Board Membership**

The backgrounds of elected members included experience in local government, the health sector, community organisations, and business. No Māori or Pacific people were elected in most of the case studies. Some concerns were raised that the electoral process did not ensure an appropriate mix of candidates. Appointments were used to add Māori, Pacific and business representation onto Boards. The appointment process was widely appreciated for rounding out the necessary skills, although one informant commented that by the time Māori and Pacific representation was taken care of, it generally only left scope for one person with business or financial skills. One informant (B:29) cited a Canadian model, where candidates are assessed by a selection committee prior to an election process, as more likely to ensure high calibre

people are elected onto Boards. One case study Board (D:17) had two of their five Māori members elected. This Board (D:15) was described as “*a nicely balance Board in lots of ways but could do with more business skills*”.

Most case studies reported that Board members freely drew on their background knowledge and experience. For example, one case study (B:29) noted how individual Board members took up specific roles aligned with their experiences and skills, which was considered advantageous. Another case study (C:19) observed members drew on their personal backgrounds to offer information and ask questions on issues where they already had detailed knowledge.

One case study Board (C IR:12) had three members resign during the term in office, including one elected member and two appointed Māori members. Although other Board members made representation to the Chair requesting these positions were quickly filled, it was noted that the Chair was not confident this would occur and the report made no mention of these positions being replaced for the remainder of the electoral term.

In one case study (E:17), Board members considered “*we’ve got a good mix of skills*” whereas provider informants outside the Board were sceptical of the election throwing up a well balanced Board. Informants in the second round of interviews pointed out that the right skill mix was only part of the formula for the Board functioning successfully, as they also had to learn their role.

## **2.4 Representation**

Although the legislation requires all members to be accountable to the Minister, most case studies observed elected members also felt accountable to their constituencies. For example, in one case study (A:11) informants were clear that their primary accountability was to the Minister but at least one member saw himself as a ‘*watchdog*’ for the community. Some informants pointed out that appointed members also had their constituencies. As members settled into their roles the differences

between elected and appointed members became less obvious. The perceived dual accountability of some elected members did not cause difficulties for Boards, and the appointed members were reported to be sympathetic to the elected members' need to represent their communities.

The case study (C:22) with a collective accountability policy reported the minority of members who wished to speak out publicly were placed in a dilemma between their perceived accountability to their communities and their obligations to the Board policy. The issue was particularly contentious leading up to the 2004 elections as it conflicted with members desire to speak out as part of efforts to gain re-election. Some candidates campaigned that they would not be gagged and promising to *“advocate more vigorously on behalf of the [district’s] people.”*

One case study (A:11) reported Board members' personal goals for their term in office, which included being a voice for the community to look after the collective interests. Māori Board members felt extra responsibilities to promote understanding of issues pertaining to Māori and to advance Māori health.

One Board (D:16) has developed a system of each Board member keeping in contact with and representing a particular service area of the Board's operation, which was usually allocated on the basis of interest. Informants described this positively as it helped ensure each service area within the DHB had an advocate on the Board.

## **2.5 Board Performance**

Training for Board members was organised through the Ministry of Health, including one day of orientation provided by the Ministry of Health, and one day of training facilitated by the Institute of Directors. One experienced Board member (B:29) felt the training organised through the Institute of Directors was too abstract and that training could have been better provided by former health sector Board members. Some Boards also held ongoing training seminars. For example, one case study (A:11) had an ongoing training schedule through a series of seminars on a wide range

of topics, e.g. disability awareness, managing conflicts of interest, and Primary Health Organisation development.

All case studies spoke of the steep learning curve for most members and that it took some time for members to become comfortable with their individual and collective roles. Researchers observed a growth in Board member confidence and knowledge with a concomitant increase in constructive debate and the challenging of issues. Informants confirmed they had to acquire that understanding and confidence before they could effectively question management and undertake the tasks necessary to govern the organisation.

Informants across case studies singled out some aspects of the role as challenging for new members: the boundary between the governance role and that of management, and understanding the extent of their role when important allocation issues are decided by Central Government. One case study (E:16) reported that some Board member and manager informants perceived a need for clarification of the scope of the Board's activities in relation to central Government. In this case study a number of Board members were frustrated at the political processes and the lack of resources which they perceived to constrain their ability to make a contribution to strategic decision-making. One clinician (B:29) identified a need to educate Board members about different clinical specialties. Other concerns raised by Board member informants were simply the sheer number and complexity of issues to be grasped, and the amount of reading required to adequately prepare for Board meetings.

All case studies reported some concern about the disruption caused by the elections, partly because of the amount of learning involved for new Board members before they can be effective in the role and also the time it takes for Boards to function as a group. One Board member informant (E:18) suggested only half of the seats should be put up for election, or that the term be extended to five years, to maintain some continuity.

Board members are accountable to the Minister of Health, although performance of the Board, individually and collectively, was assessed internally by the Chair. Most of the case study Boards had some process of review or feedback. One Board (B:29)

used a self-assessment process which was a questionnaire based on information from the Ministry of Health and other DHBs. However, according to an informant, members seemed reluctant to undergo this self-review process, nor did they elect review by the Chair.

Another Board (A:12) found their system of performance monitoring helpful in improving the functioning of the Board. This was a dual process including annual self-evaluation forms which were then discussed with the Chair in a reciprocal feedback session. In addition this Board developed a template of desirable and undesirable attributes for the Board as a team, which members also rated and used as a starting point for open discussion on the culture of the team and to help identify further training that may be useful. Informants appreciated the openness and transparency of this performance monitoring system. This board also held informal sessions after the Board meeting to share information and to discuss issues.

Board members (A IR:10) identified features which were seen as helping their Board perform: teamwork, clear delegations, accountability of management to the Board and strategic thinking. Teamwork strengthened as members had come to understand each other's strengths and weaknesses. By the second round of interviews informants considered the Board had consolidated around a sense of purpose.

*“The maturing of the Board was seen as developing through a deepening understanding of the health sector, the role of central agencies in setting high level direction, and the limits on autonomy through the accountabilities to the Minister and the Ministry, coupled with a greater confidence in management.”*

The CEO of a third Board (D:16) developed a template for assessing individual members' performance and that of the whole Board. The individual assessment included preparation for meetings, contributions, effectiveness in specific roles, participation in advisory committee meetings, completing Treaty of Waitangi training and other education courses. The assessment of the Board included policies reviewed, resolutions passed, departments visited, Board goals achieved, Board goals reviewed or revised, standing orders adhered to and briefings given.

Some informants (D:26) defined a high performing Board as one where the Board, managers and staff work together to achieve optimal health outcomes for the people of the district. Teamwork, understanding each other's strengths, and the Board and senior staff being open and accessible were seen as pivotal to the performance of this Board (D:14, D:27).

## **2.6 The Role of the Board**

Across the case studies the purpose of the Board was defined in terms of governance of the DHB, ensuring an appropriate strategic direction for the people of that district in consultation with the community, and ongoing monitoring to continue to strive for health improvements for the district population.

In one case study the role of the Board (A:8) was defined as governing the DHB to carry out its assigned tasks of assessing the health priorities of the district and, in consultation with the public, to draw up strategic plans to translate the national health strategies into implementation plans for the local district. Another case study report (D:26-27) defined the purpose of the Board as ensuring the health services are run appropriately for the people of the district by taking the right things into account, getting the right emphasis and ensuring there is community representation. In practice this meant analysing the health needs of all of the people in the district; translating that need into plans for improving health; ensuring these plans are put into action efficiently; continuing to evaluate to show where interventions have made a difference; and addressing the residual need.

A third case study (E:16) referred to the Board as "*a barometer of whether we are doing the right thing*" as they are elected as a representative group of the communities' interests.

The Board meeting was the focal point for the monthly reporting and reviewing of all parts of the organisation. Management and clinicians provided technical advice, usually with recommendations, to the Board who make the decisions. Across all case

studies, researchers observed that as Board members gained confidence they were more inclined to challenge and debate the recommendations, or ask for other information.

Strategic leadership and strategic monitoring were two central themes to the role of the Boards. However, in one of the case studies (E:19), it was noted that much of the strategic discussion occurred at either the statutory committee level, where there is more room for debate, or at strategic workshops held prior to the formal board meeting. For this Board, CPHAC and HAC met together on the same day which also became the strategic thinking day for the Board.

*“It is at this level also that the Board addresses the implementation of the various government health strategies. The strategies are addressed by way of reviewing what are the key issues for the population served by [DHB] and developing mechanisms for consultation and discussion about best ways forward.”*

## **2.7 Board and Management Relations**

While the role of the Board was defined as ensuring the health services are run appropriately for the people of the district, the CEO and management were seen as responsible for the day-to-day operations. The management and clinicians provided the technical advice to the Board. Although the Board made the decisions, usually the CEO and management did the background research and put together recommendations. As Boards gained confidence there was more questioning and challenging of the management recommendations, rather than a “rubber stamping” process.

Those Board members who had previously been involved in earlier health systems commented on the differences. One Board member (E:15-16) stated the Board had moved to a hybrid of a company and a public board, that is, combining the role of monitoring financial performance and being representative of community interests. The case study reported “these comments reflect the shift that has occurred from a corporate, business model of governance to a more community-based, political model

of governance where substantive issues of community concern have a much greater presence.”

Managers in another case study (B;31) with experience of previous health systems found the DHB system more bureaucratic: more reporting to various committees with the boundaries between managers, the Board, and statutory committees not always clear.

Most case studies reported some confusion between governance and management roles, particularly in the earlier phases of the Boards’ term. Managers commented on Board members encroaching on management and operational matters, while conversely, some Board members resisted what they perceived as efforts by management to manage the Board into rubber stamping recommendations forwarded to them. Most case studies, but not all, observed relationships between Board and management to strengthen over time as mutual understanding of the governance and management roles grew.

For example, one report (C:23) stated there to be a “good marriage” but this had been “hard won [by] constant vigilance.” The clarification of these relative roles over time was associated with more productive teamwork. This case study noted there were still a residual number of managers who regarded the Board as needing to be “managed”. These one or two individuals existed side by side with examples of effective working relationships. There were still “grey areas” where it was more difficult to draw the line between governance and management. For example, management sought to reduce expenditure by ceasing to employ community midwives, but did not communicate effectively with the Board which regarded this as a strategic decision in which they had a role.

Three case studies noted some issues arising over the amount of detail management forwarded to the Board. One informant (A:15) complained that their management was too economical with the detail behind recommendations, although others within the same Board spoke with appreciation of the managers keeping them well informed. A second case study (C:20) reported that strategic decisions were not always being debated fully at the Board as the issues come to the Board “*a bit sewn up*”. A third

case study (B:30) spoke of the struggle to have the right amount of detail presented to meetings, reflected in the two opposing points of view: *“If I can’t understand something of the management, I can’t do my governance’ and ‘if you give a board detail, they’ll work in detail, which means they start to work ... in the management area”*.

In one Board (B:30) a close working relationship developed between the Pacific Board member and the Pacific health manager. This was seen as *“profoundly beneficial” in establishing “a Pacific presence in the DHB.”*

## **2.8 The Role of Clinicians**

The case study reports noted various themes of concern in researching the role of clinicians: the role of clinicians on Boards, the communications between clinicians and the Board, the involvement of clinicians in management processes, and the need to engage clinicians in the wider goals of the DHB. There was wide variation between case studies.

One case study (B:32) noted the relationship between Board and clinicians was an area of concern for all parties. This Board included some clinicians, and also some managers have clinical backgrounds. Two informants (B:32) regarded clinician Board members who were also employees as constrained by a *“fundamental conflict of interest [in their Board role]”*. Other Board members acknowledged the constraints on the roles these members could contribute, e.g. they could not chair the HAC, but considered their expertise could be used as long as the conflicts of interest were properly flagged.

There were very mixed reports (B:32-33) from clinician informants in this DHB, with some senior clinicians stating they were listened to and one (clinician) informant commenting *“by and large we had a very supportive Board”*. Other informants referred to the legacy of *‘anti-doctor’* management, that clinicians *“at the coal face”* felt they were not taken seriously, and one Board member informant regretting *“that a*

good working relationship was not established between the Board and clinicians in the 2001-2004 triennium.”

The main concern within this DHB was to ensure clinicians took a broad organisational perspective. This was seen as crucial to the DHB’s goals of strategic resource allocation, integrated models of care and population health. One informant considered the only way to achieve this was to meet on a regular basis to reinforce an organisational perspective to develop the clinicians’ identification with the DHB as a whole rather than their part of the sector. Bringing senior medical officers together socially was also found to be helpful. Challenges faced by funding and planning teams included how their few personnel could establish relationships with the large pool of clinicians and develop the appropriate boundary between them and the provider arm without capture by the hospital side. Informants indicated there were some gains from these efforts. Clinicians praised the CEO and approved of the style adopted. *“The CEO’s style was to ensure that clinicians received information about finances and were able to present views from their services and be heard, which had happened less in the past.”* Overall the DHB management was considered to listen to senior clinicians and seek their advice.

A second case study (C:13) noted that HAC was the main forum through which senior clinicians had input into governance. The Executive Director of Nursing and the Chief Medical Officer both attended and reported to this committee, enhancing the clinician/ management/ Committee interface. Other clinicians also attended this committee. In addition a Clinicians’ Board was established in 2003, providing a second channel for clinicians’ views to be brought forward. Despite these developments, some informants still observed there to be poor relationships with some clinicians which were attributed to poor communication from management, poor leadership, and failure to engage clinicians in the vision for the future. Some commented clinicians were still “very silo functioning.”

A third case study (D:27-28) observed that under the DHB model, managers engaged the clinicians more in a collaborative, partnership role than has happened in the past. Informants from this DHB reported good relationships between management and clinicians, noting a change from previous regimes. The Health Reform’s emphasis on

transparency and openness was considered helpful in achieving this positive change. The clinicians were described as advisory to management and the Board, but without having sign-off on spending decisions. Clinical staff had input into planning processes and some clinical managers attended the Board and committee meetings. There was also a Clinical Board which represented all hospital areas and has responsibility for formulating clinical policy, which was tabled at the Board meeting. The CEO attended the Clinical Board, and conversely, the Medical Director attended the executive management meetings. Board members were also invited to attend the Clinical Board.

In this DHB the clinicians had input into the planning process to produce the DAPs and are increasingly involved in debates over spending priorities. One service manager noted they individually had responsibility to ensure the work in their section was consistent and supportive of the overall DAP and strategic direction. In response to criticism from clinicians over the spending priorities, *“Management threw down the gauntlet and said ‘okay, you decide with this limited money’.”* Apparently this was a helpful exercise as the clinicians did generate some ideas but also realised more fully the difficulties of resource allocation within those spending constraints.

A fourth case study (A:49) reported informants considered relationships between management and clinicians have grown and strengthened since the health reforms. The DHB has recently formed a Clinicians Board as a channel through which senior clinicians can have input into management decisions. A representative from the Clinicians Board attends the provider arm management team which was considered to bring a clinical perspective to the financial decision-making.

## **2.9 Board Accountability**

Key roles for the Board are reporting on accountability measures, providing strategic leadership to the DHB, and strategic monitoring to ensure the goals of the DHB are being achieved.

The Board of each DHB is accountable to the Minister of Health through the annual purchase agreement and the Crown Funding Agreement with the Ministry of Health. According to the NZPHDA Part 2 s 10 the Crown funding agreement refers to the commitment of the Crown to provide money in return for the provision or purchase of services specified in the agreement. Initially under the Public Finance Act 1989, and then in accordance with the Crown Entities Act 2004 Part 4, each DHB must prepare Statements of Intent, annual financial statements and annual reports.

The Crown Funding Agreement (CFA) defines the formal relationship between the Crown and each DHB. Through the CFA the DHB is funded annually to perform three types of obligations: funder of services, governance and funding administration, and variations to provider services. Each DHB reports to the Ministry of Health on a quarterly basis against indicators as set out in the CFA. The indicators are intended to focus DHB activity on priority areas, monitor DHB activity, hold DHBs accountable and allow comparison between DHBs' performance. The CFA details the accountability documents required to ensure the DHB has complied with legislative requirements and guidelines, which are the District Annual Plan (DAP), the Statement of Intent (SOI), and the District Strategic Plan (DSP). The DAP includes indicators of DHB performance as well as performance targets. Financial incentives were built in to the reporting schedule: 'early status payment' was awarded to those DHBs who completed the DAP within the established time frame and means the DHB will receive funding at the beginning of each month, rather than at the end of the month, thus improving cash flow.

The aim of the SOI, and in particular, the Statement of Service Objectives and Performance Measures is to demonstrate the impact of the DHB's activities on its primary objective of 'improving the health and wellbeing of people' living in the district. According to The Public Finance Act (now Crown Entities Act Part 4 s 138), the DHB is required to clearly state in the SOI the objectives and targets and how they are to be measured. Audit New Zealand undertakes an annual audit of this work.

One interim case study report (C IR:16) described an early (2001/2002) audit process, which is illustrative of the learning process for all involved. The Audit New Zealand report included aspects of the DHB's financial and service performance. Significant matters arising were reported back to the DHB's Finance, Audit and Risk Committee in March 2003. The report states:

*“The key area for improvement was with respect to information on non-financial service performance. These indicators are signalled in the SOI and reported in the audited Statement of Service Performance (SSP). The audit concluded that the large number of low level objectives and performance targets included in the Statement of Intent made assessment of key performance areas difficult. Audit New Zealand acknowledged that the SOI requirements had caused widespread confusion across the sector, that this is a relatively new area for DHBs and noted that the quality of service performance reporting would be expected to improve over time. The audit team made five recommendations in this area, including the refining the SOI to include only key objectives and targets and considering the characteristics of good performance measures.”*

In responding to these recommendations the DHB audit team worked with the Funding and Planning division to address this. It was noted that the SOI and the SSP are the board's key accountability documents to both Parliament and the constituents of the district and therefore the performance targets in the SOI need to reflect accountabilities to these key parties. Efforts were also made to ensure clear links between the DSP, SOI, SSP and the DAP. The second round of research reported that these efforts had made the DAP a more useful document, and that there was now an overall view of how to link the Core Directions and the health service priority areas. The SOI was seen as a disciplined way for the organisation to plan for the three year period and project the forward funding path.

In this case study informants were initially critical of the lack of clarity in the Ministry's reporting requirements, but considered that some progress had been made in this area by the second round of data collection. The specifications of the 2003/2004 Crown Funding Agreement were "reportedly much tighter than previously." However the Service Coverage Schedule (SCS) of the CFA which sets out the baseline of services to be funded was assessed to be 'very poorly defined.' Although the Ministry of Health expected that the process of prioritisation will overcome the non-specific, open-ended nature of the SCS, from the DHB perspective the SCS exposed the DHB to a potentially unlimited liability to fund services, which was seen as being in need of addressing and capping.

The Ministry's reporting requirements are prescribed and include quarterly reports on the accountability indicators, a monthly financial report, staffing reports, against a reporting template and an annual report. Criticisms of the reporting requirements across the five case studies were relatively consistent and included:

- the lack of feedback;
- that DHBs are "overwhelmed with monitoring detail". Rather than concentrating on high levels of detail across twenty-one different organisations, it was suggested the Ministry should monitor progress nationally. At least one case study found reporting requirements have continued to increase over the research period.
- reporting 'the same stuff over and over';
- some of the reporting is onerous, not helpful and sometimes silly, e.g. a requirement to report the number of Māori women giving up smoking during the first, second and third trimester of pregnancy, which prompted the informant to speculate where the dataset should be drawn from (B:53);
- the reporting does not capture health outcomes, patient satisfaction nor what difference the contract makes, but instead focuses on processes and inputs;
- the excessive management time and resources consumed by the monitoring activities;

- not all questions are meaningful for all DHBs. and the given accountability indicators incorporated assumptions about causality that were not always valid (B:54);
- parts of the Ministry appearing to work in isolation so that feedback was often uncoordinated;
- the reporting is burdensome, particularly for small DHBs; and
- the opportunity costs. One informant considered the time could be better spent on ‘developing and improving future health services’ and another saw the monitoring to be a barrier to being innovative as it kept them focussed on the past.

Some informants saw the greater transparency in accountability processes as an improvement. According to one informant (D:33) there had been a breakdown of accountability prior to the 2001 health reforms.

Some positive suggestions were made to improve accountability reporting. Informants suggested the Ministry should:

- monitor nationally at a higher level;
- reduce the volume of reporting by requesting reporting on fewer variables but ones selected to tell a particular story;
- use a more trusting, flexible process;
- develop better understanding of what happens “at the grass-roots level in DHBs”;
- adhere to their own timeframes more rigidly;
- define the mutual responsibilities of the Ministry and the DHB more clearly; and
- the Ministry should hold more face to face meetings.

It was also suggested that monitoring should be the responsibility of an independent authority so that the Ministry is no longer *‘judge, jury, and executioner’*.

Strategic monitoring was conducted through the prescribed key performance indicators reported to the Ministry of Health, and whatever additional measures which were instigated by that DHB. Some Boards developed their own monitoring tools which were more meaningful to that DHB.

Not all the comments on the reporting requirements were negative. In one case study some informants (D:33) found the reporting processes “necessary” and one commented “*some of the measures are quite helpful for us as well*”. The reporting to the Ministry was considered a useful starting point for the DHBs own strategic monitoring. The Board added seventeen indicators of performance that were clinically based, which were monitored quarterly and reported to the Board. There was also planning in place to extend formal, as opposed to anecdotal, monitoring of service gaps to be reported as a monthly HNA to the Board.

Another DHB (C:21-22) developed their own Strategic Monitoring Tool (SMT) in response to the high priority placed on this by Board members. The SMT included monitoring of outcomes related to Core Directions and secondly, on Key Projects. The Core Directions report “was developed to identify goals, strategies and outcomes from the District Strategic and Annual Plans” and monitored progress on these. The researchers noted that considerable progress had been made towards monitoring progress on outcomes relevant to the Board, and that the Board itself had been instrumental by insisting on the development of tools with outcome orientation. Other sources of information used by that Board to monitor progress included the CEO’s regular report to each Board meeting, requests from Board members for update reports on work in progress, and specific projects to examine areas identified as of concern.

Within a third case study DHB (B:54) internal monitoring included waiting times for treatment, hospital consumer complaints, and patient satisfaction surveys.

A fourth DHB (E:19) was keen to provide monitoring to determine the extent it was achieving its strategic goals, by conducting research to monitor progress more effectively for their district *“over and above the regular provision of the prescribed key performance indicators to the Ministry of Health.”* However it lacked the management capacity to do so, particularly as in the early phase of the reforms the staff were *“overwhelmed with the requirements of setting up the DHB, renewing contracts with providers and responding to questions or requests for information from Board members.”*

## **2.10 Statutory Committees**

The statutory committees make recommendations to the Board rather than being decision-making bodies. The NZPHDA requires DHBs to establish three statutory committees: Community Public Health Advisory Committee (CPHAC), the Hospital Advisory Committee (HAC), and the Disability Supports Advisory Committee (DSAC). In addition each DHB may establish any other committees that it deems appropriate. Other committees adopted by various DHBs (each DHB has only some of this list) included the Remuneration and Appointments committee; the Property committee; The Finance, Audit and Risk committee; Strategic Communications; and a committee to oversee building and development plans.

In most of the case studies, the committees are made up of a mixture of Board member representatives and external members who have been chosen to complement the background knowledge and experience of the Board members, and to ensure the desired skill mix is present overall. Two of the case study Boards assigned Board members to committee membership rather than appointing community representatives. The division of tasks between committees also varied between case studies.

### **Case study A**

In this DHB (A:16-19) the Community Public Health Advisory Committee (CPHAC) oversees the funding decisions, including the funding allocation to the other committees. The Hospital Advisory Committee (HAC) oversees the provider arm. Within that DHB the DSAC has a relatively truncated role of promoting awareness of disability issues.

Informants from this case study considered the statutory committees to make ‘a meaningful contribution to the Board’s decision-making, by making ‘very strong recommendations’ back to the Board. Informants attributed their committees with undertaking a lot of the debate, analysis and evaluation on particular issues. The fresh views of the external members were also appreciated by Board members.

### **Case study B**

Within this case study the committees were more controversial due to tension concerning their role and the boundaries between the committees and the Board. In July 2002 the Chair of the Board (B:17-18, 22-23) developed protocols to clarify boundaries between the Board, committees and the Executive and made explicit that it was the Board’s role to direct the committees. Tensions arose when the committees developed their own initiatives and independently asked for information from the Executive management team. This contrasts with, for example, Case study A where the committees routinely requested whatever information from management they regarded necessary to tease out the issues considered relevant to their tasks at hand. Some of the disagreement may relate to pressure on the available funding and planning resources within case study B. Some statutory committee informants had proposed that there should be a secretariat assigned to support the Board and committees but this motion was defeated.

The tension between the Board’s leadership and the committee contributed to the decision of the CPHAC chair, a Ministerial appointment, to resign before completing the electoral term.

The Board reviewed the committee membership mid-term. The external members were appreciated for their contributions, for providing “*a reality check*”, and because “*It’s brought voices that would not otherwise come through any other governance arrangement*”.

The roles attributed to the statutory committees within this case study were filtering information; acting as a “sounding board” for the Executive; and allowing community input. Some policy development work was conducted in CPHAC and DSAC whereas HAC was more concerned with monitoring.

Most informants considered the benefits of the committees outweighed the costs but other informants expressed reservations, including:

- the committees only have the power to advise and the Board does not always adopt the advice;
- because so many of the Board members sit on the committees, there is a possibility of the Board talking to itself rather than listening to community input; and
- the committees ‘*have muddied that usual boundary between governance and management and operations in a way that is unhelpful.*’

One informant expanded on why she/ he considered the committees were unhelpful:

*“[They] take value out of the organisation rather than adding to it ... they confuse the governance-management role, they create an enormous amount of work ... You bring in a whole lot of people who’ve got ... special interests, they act as individuals, they are sitting uncomfortably between high level policy and strategy and governance and operational ... most of them have got operational experience, so their tendency is to think operationally, but as a committee they don’t have the management structures to actually work as a body and ... the end result is that they take up a lot of time, they potentially undermine coherent initiatives and ... sometimes they do, but mostly they don’t add a great deal.”*

### **Case study C**

The informants in a third DHB (C:10-11) gave mixed accounts on the committees' effectiveness, with one account suggesting the committees are "tightly managed" and were not expected to take initiatives. The committee reports to the Board in this case study were initially fairly cursory and made by a staff member. The reporting process evolved throughout the term in office and by 2004 the committee chairs reported in person and more fully to the Board. All strategic planning work is channelled through the committees. The preparations and undertaking of these meetings were noted to be time consuming for management and committee members.

This DHB had undertaken a review of the statutory and other advisory committees during 2003 to refine their roles, clarify boundaries between them, to develop work plans for each committee in alignment with their roles, and to streamline the pathway of papers from the committees to the Board. The Review also recommended the committees work more closely together to "reduce double handling" of issues and papers, leading to some joint forums of the three statutory committees. In addition the committee chairs have met regularly in an effort to avoid duplication of work.

### **Case study D**

The fourth case study (D:29-30) Board Chair "had made a pragmatic decision" that all Board members were also committee members. It was also decided that all committee meetings and the Board meeting would be held on the same day. These decisions were designed to maximise cost-effectiveness by avoiding double discussions. However, some Board members later had disquiet about the unilateral decisions and as a result of their concerns, the Board reviewed the representation on the committees, with the objectives of improving transparency, ensuring adequate community representation, and having more independent decisions coming through to the Board which are less biased by Board perceptions.

This review had been completed by mid 2004 and recommended that membership should consist of three Board members and four community representatives, with one of the Board members being the Chair. The purpose of the committees was clarified also: the committees are advisory to the Board rather than being a community committee.

Within this DHB the titles of the committees did not sit comfortably with the way services were organised within that DHB, for example, mental health services could be included in both CPHAC and HAC. Informants stated they would prefer provision is made for statutory committees but without them being so prescribed.

The committees attracted mixed reports within this DHB, ranging from one who thought they were '*rubbish*' to another who considered the committees were working well, as judged by the quality of debate.

### **Case study E**

A fifth DHB (E:21-22) had a different solution to their statutory committees. In this DHB the CPHAC and HAC operate as "committees of the whole" with all Board members included as committee members. The DSAC consisted of equal numbers of external, co-opted members and Board members. Soon after the statutory committees were established, the Board decided to combine the CPHAC and HAC, although each retained its own Chair. The rationale for this was to facilitate the strategic goal of moving resources from the hospital into the community. However this merger was reversed in July 2003 because the NZPHDA requires separate meetings with a separate agenda. At least one informant complained the statutory requirements are too prescriptive and they would prefer greater freedom to address issues as they see fit.

Within this DHB, CPHAC and HAC run consecutively on the same day which was described as the Board's '*strategic day*' when members can engage with one another on major strategic issues. Informants commented that the Board is able to avoid reiterating discussions across committees by these arrangements. The researchers reported there was strong approval of this setup. Although some informants had initially questioned the relative costs and benefits of having statutory committees, in the second round of interviews (mid 2004), all thought the committee meetings were worthwhile.

### **2.10.1 Community and Public Health Advisory Committee (CPHAC)**

Broadly speaking, CPHAC advises the Board on population health issues. In most Boards it is concerned with the strategic orientation of the DHB towards community health to achieve public health objectives. Within the case studies the CPHACs' role varied, encompassing a range of tasks which included some, but not all, of the following:

- priority-setting;
- determining strategic direction;
- monitoring progress on strategic goals;
- advising on funding priorities;
- working on particular policies or projects; and
- providing a means of engaging with the public.

The statutory requirement to maintain a CPHAC has been met in quite different ways by each of the case studies. Key dimensions that determine the actual role and function of the Committee are:

- the membership of the committee;
- who sets the Committee's agenda;
- the engagement with the community;
- the source of information supplied to the Committee;
- whether the Committee acts as a tool of the Board or initiates independent advice;
- how the Committee's deliberations are communicated to the Board; and
- what issues the Committee addresses.

### **Case study A**

The CPHAC (A:16-17) was made up of a mixture of Board and co-opted external members who offer particular skills or knowledge. The membership included both a Māori Board member and an external Māori representative. CPHAC made recommendations to the Board, which held the decision-making authority.

The Committee focused on the “*broader vision of the community rather than just the hospital*”. One informant credited the Committee with doing the analytical, evaluative work for the Board, including asking management for the background information or setting up reference groups.

In this DHB the CPHAC advised on the funding allocation to services represented by other committees, which gave it an elevated status. CPHAC tried to control the provider arm deficit but this tended to generate some tension between the CPHAC and the HAC.

CPHAC called for proposals when new funds were made available, then decided which project was worthy of funding. The Committee has been involved in PHO development, reviews of existing facilities, and policy development for a range of services.

Although the assigned task did not change over the research period, it was observed that the Committee made an increasing contribution over time as the Committee became more skilful, as members gained a better grasp of the overall context, and as contracts have come up for renewal.

### **Case study B**

The CPHAC was reported (B:24-25) to be at the centre of the activity of the Board: setting priorities, debating values and overseeing the principles and roles for the allocation of funding. This committee was informally responsible for developing the draft Strategic Plan. The Committee alternated monthly meetings with forums on diverse topics which were initiated “to advance and focus discussions, to promote critical thought and engage with the community.”

The Committee combined Board members and external members, who were selected from key community organisations. Members used reference groups, forums and their own resources and contacts to help them assess priorities. According to informants there was no serious disagreement within CPHAC over the strategic direction.

However other stakeholders experienced some difficulties concerning CPHAC :

- There was confusion within the Board over whether the Committee was concerned with policy development or policy review.
- There was disagreement over whether the agenda should be under the control of the Board Chair or whether the Committee took its own initiatives. Tension between the Board Chair and the Committee led to the resignation of the CPHAC Chair, a Ministerial appointee, during 2004.
- The heavy workload of the Committee strained the resources of management who were not always able to supply the reports the Committee requested. In the absence of management reports, members resorted to other sources of information.

According to a Committee member, although theoretically the Committee was a tool of the Board, the directions from the Board to the Committee were *'not always a clear proposition'* and did not necessarily generate public interest. It was estimated by an informant that 90% of the Committee's advice was to Planning and Funding, and only 10% advice to the Board.

The Board Chair determined CPHAC's minutes were the most appropriate form of communication to the Board and therefore there was not a direct interaction between the Board and CPHAC members.

The Committee oversaw the allocation of funding, but was observed to be more oriented to service development than identifying disinvestments. It was suggested by one informant that CPHAC may operate better if it engaged more with key others (outside the Board) and develop relationship further with the Māori Partnership Board.

The CPHAC programme for 2004-2006 indicated an increasing focus on public health issues, including services for Māori and for Pacific, reducing inequalities, nutrition, social environments, and building public health into all of the DHBs work programmes.

### **Case study C**

The stated (C:14-17) role of the CPHAC “*is to advise the Board on the health needs of the population, risks to health and the priorities for the use of available health funding.*”

Within this DHB the CPHAC was assessed as still establishing itself after the first round of research. At the second round of interviews, CPHAC continued to attract very mixed views. One informant credited it with having an important strategic role, another informant considered that the potential for influence over priority-setting and engaging with the community was still to be realised, and a third opinion was that the Committee was redundant as the work could be handled by the Board. The researchers concluded there was uncertainty about the expectations of CPHAC. However they identified five areas where there were expectations of CPHAC:

- Overseeing the strategic planning process. This work is sporadic.
- Reviewing detailed strategies and plans. The committee reviewed and commented on a number of public health plans and strategies before they went to the Board, thus performing a ‘check and balance’ function, and thereby freeing up the Board for strategic issues. In doing so the committee also advocated for more of a public health focus. However some expressed reservations about the committee being adequately equipped in both expertise and time.
- Monitoring non-provider side performance. The reporting templates to CPHAC were improved to assist with monitoring, including the Strategic Projects Monitoring Report, the Provider Financials and Activity Report (from Funding and Planning) and the Strategic Projects Monitoring Report (from Population and Peoples’ Health).

- Participating in the budgetary/ priority-setting process. In practice the Board was dominated by deficit reduction, and the CPHAC was stymied in any discussions towards long term planning and population health. Also Funding and Planning was not resourced adequately to provide the necessary information to CPHAC to enable the committee to challenge the allocation of funding.
- Providing opportunities for community input/ engagement. In practice this was seen as a management function and the committee has not directly got involved in consultation.

Until 2004, the feedback from CPHAC to the Board was delivered by officials. This was then changed to the Committee chairs delivering their own reports. However this feedback was scheduled for the end of the three hour meeting and was delivered verbally. In combination, this was considered by informants to devalue the work of CPHAC. Furthermore, the lack of written report of the Board meeting has kept the community members who do not attend the Board meetings marginalised from those processes. From 2005 the CPHAC meeting minutes were to be incorporated with the Board papers.

CPHAC informants noted a certain affinity with DSAC within that DHB because of issues in common, resulting in some joint forums and the merging of the two committees in 2005. On a more negative note, the affinity was reported by another informant as based on a perception that both Committees were peripheral to the work of the Board.

The researchers noted CPHAC has only had minimal involvement with PHO developments, and speculated this may have contributed to the lack of progress within the DHB on primary health care strategic development overall.

It was suggested by informants that more interaction between CPHAC and HAC is necessary for more effective strategic functioning and decision-making. It was also suggested that CHAC and HAC could collaborate on reviewing service allocation between in-house and community providers.

Several informants noted that maintaining a high level of committee performance, particularly a role in reviewing patterns of expenditure and influencing budgetary processes, was difficult due to 'a number of resignations,' a meeting cancelled because of lack of quorum and another meeting proceeding without a quorum. The chair of CPHAC conducted a review of the Committee in October 2004 which generated some constructive suggestions towards making the contributions of community members more effective, including better orientation and induction, an annual planning session, and including the community committee members in some of the Board workshops.

#### **Case study D**

CPHAC (D:32) advised on public health issues, and also mental health. Within this DHB the division between Committees was arbitrary and did not sit comfortably with the way services were organised, as for example, mental health encompassed community and hospital based services.

The Committee has undergone an evolution during the period of research. Initially the Board Chair made a pragmatic decision to hold all meetings (Board and the three statutory committees) on the same day and all Board members were automatically also Committee members. Even at the first round of interviews some expressed disquiet about the lack of community membership, and by September 2004 the Board had agreed to review membership and to have each Committee membership consisting of three Board members and four community members. By the second round of interviews (mid 2004) the CPHAC was being held on a separate day, the Board had made a commitment to review the operation of the Committee and a membership review was underway. This was motivated by a recognition from the Board the Committee could fulfil a more useful function.

Informants complained that the role of the Committee has been poorly defined and therefore they found it difficult to ascertain whether or not it was fulfilling this role. The functions of the Committee were all defined in negative terms:

- It has no delegated authority regarding funding decisions.
- It has no input as a committee into DSP or DAP, nor did it make submissions with regard to the Government's strategies.
- It was not involved in the development of PHOs apart from members receiving reports from the DHB manager of the process.

By the second round of interviews, some informants were critical of the poor attendance of Board members who were also committee members.

### **Case Study E**

In this case study (E:20-21) all Board members were also on the CPHAC. Initially there were also two co-opted external members but these positions were terminated.

The CPHAC functioned within this DHB as an extension of the Board, to discuss the strategic issues in more depth. For a time this Committee was merged with HAC, though each retained different Chairs, to address directly the desired re-orientation from hospital to community focus. However they were separated again to meet statutory requirements of separate meetings and agendas.

The consensus from informants was that involving all Board members in CPHAC (and HAC) and the focus of the meeting worked well. Both these meetings were held the same day, giving Board members "*a strategic day*" as compared to the "*nuts and bolts*" Board meeting day.

### **2.10.2 Hospital Advisory Committee (HAC)**

Although the HAC in each case study focused on the hospital services, the approach taken by each Committee was quite different, with the emphasis varying between operational aspects, monitoring, quality assurance, financial scrutiny, and the strategic integration with community services.

Some dimensions of difference include:

- membership of the Committee
- the inclusion of others, particularly managers and clinicians;
- the breadth of content; and
- the quality of relationship with key others.

#### **Case study A**

The HAC (A:16-18) advised on the operational policy and funding with regard to the hospital. According to informants, the Committee has “*come together well*” and had a clear view of its role of making recommendations to the Board as the decision-making authority.

Membership consisted of a mixture of Board and co-opted external members who offered particular skills or knowledge. The membership included both a Māori Board member and an external Māori representative.

Within the DHB, the CPHAC recommended the funding allocation that HAC can work with in to make its recommendations concerning hospital and specialist services. This structuring was designed to allow for the strategic re-orientation to the community while constraining the hospital deficit.

While most HAC meetings were open, and the press attended for the open part of meetings, the committee did have a closed section for the discussion of confidential matters, which were mostly matters of commercial sensitivity or issues to do with employment, such as staff competence. One committee member stated having meetings open to the public did not affect decision-making, as people quickly became used to meetings being open and “*just got on with it*”.

#### **Case study B**

The HAC (B:23-24) was “well managed and well chaired” according to the case study report. The HAC consisted of Board members and co-opted external members, and was always attended by either the Hospital General Manager or the CEO. In addition the Director of Finance frequently attended.

According to an informant the role of this committee was relatively well defined, compared to other committees. The matters dealt with by the Committee included:

- all hospital health services (HHS) operations, financial aspects and any implications arising;
- workforce issues;
- quality issues and accreditation;
- mental health services;
- monitoring, working with internal auditors and drawing on standards from international benchmarks;
- providing information to the Board on waiting lists;
- working with hospital costs by breaking down into the components and then endeavouring to make changes, such as by new models of care and the control of equipment purchasing; and
- developing the DSP, with an emphasis on an integrated continuum of care, necessary for the hospital to move services into the community. In doing so, clinicians groups made submissions through the HHS General Manager. Senior Clinicians also made direct submissions, though the focus of the group was on whole services rather than single professional groups.

The style of the Committee meetings was described as very open, with both public and interested staff welcomed, and having a culture of openly airing issues of concern.

### **Case study C**

The role of HAC (C:11-14) was defined as “monitoring the financial activity of the hospital services and any strategic issues that affect that functioning.” Challenges to the Committee were the significant financial deficit, the size and complexity of the Hospital and Specialist Services division, gaining access to the information needed to allow the Committee to effectively undertake its job, and ensuring “the right focus on production.”

Membership consisted of half Board members and half co-opted community representatives.

At the time of the interim case study report, the HAC was noted to be “*a significant and powerful committee with a monitoring control over a substantial part of [the DHB’s] expenditure.*” The bulk of its work was assessed as “*business as usual*” continuing from the CHE model. One informant considered the potential achievements of HAC were “*yet to be realised*”.

In 2004, the HAC was reported to have mainly been concerned with monitoring the financial deficit and hospital performance issues. Informants were reported to be disappointed that the potential for a more substantial contribution had still not been realised due to inadequate information in terms of quality, lack of robust analysis and synthesis, which was attributed to a lack of capacity and capability on the operational side with regard to numeracy and analysis. It was also speculated there may have been “*stonewalling*” by management.

The Board retained a strategic role in regard to hospital services. HAC made only four recommendations to the Board over the duration of the research.

With the persistence of the deficit HAC has taken a proactive, interventionist approach in its monitoring role, requiring hospital management to report to the Committee and also to alert the committee to impending problems. Although the relationship between HAC and management was judged generally cordial, the effectiveness of the relationship in terms of the desired goal of improving hospital performance was questioned.

HAC was also the interface between governance and clinicians. The presence of HAC has led to regular reports from senior clinicians and a brokering of the clinician/management/Committee relationship. “A reasonable number” of senior clinicians were observed to attend HAC meetings. A Clinical Board, formed in 2003 and chaired by the Chief Medical Advisor, provided a channel for clinicians’ views to be brought forward, either to HAC or to the Board.

However the relationships between governance and clinicians were still regarded as strained. Informants indicated there has been a failure to engage the clinicians in the wider strategic vision for the Board, “*silo functioning*” persists, budget setting is determined by management and financial officers without “*buy-in*” from clinicians, and the Proposal for Change paper which suggested restructuring of the management arrangements for the Hospital and Specialist Services Division (June 2004) received “an extremely negative response from both individual clinicians and clinical associations.” The reaction to the latter paper was considered by the researchers to reflect reaction against the lack of consultation rather than necessarily the content of the proposal. The Clinicians Board were found at this time to offer a more appropriate channel for involving clinicians than HAC, demonstrating the limitations of the role of the statutory committee.

#### **Case study D**

Within this DHB (D:30-31) the role of HAC was defined as monitoring hospital performance and spending, and overseeing accreditation. According to informants, the committee has made no recommendations for new services or disinvestments, nor does it recommend particular providers over others.

Relationships between HAC and senior management, hospital managers and senior clinicians were described as “*excellent*”.

#### **Case study E**

All Board members are also members of HAC (E:20-21). For a time this Committee was combined with CPHAC, with the rationale that this promoted the strategic focus desired by the Board for shifting resources from hospital to community. The meetings were separated again to meet the statutory requirements, although remained on the same day. HAC was chaired by a GP Board member, which avoided the conflict of interests of having a chair from the hospital sector but afforded the committee the benefit of having a chair who understood clinical matters.

The focus of the Committee was the efficiency and effectiveness of hospital providers. It was observed by researchers that there was “little indication of the larger hospital-related strategic issues being debated” although this was from the first round of research data collection. At the second round the main value for informants was considered to be that it allowed members to get acquainted with issues in more detail.

### **2.10.3 Disability Support Advisory Committee, (DSAC)**

The role of DSAC was defined as advising on disability support, advocating for the disabled population, advising on the implementation of the Disability Strategy, and raising awareness of matters relating to disability. Most DHBs saw their DSAC’s role to be intrinsically tied up with the devolution of funds for the older disabled. The more successful and influential DSACs filled a wider role, including that of advocacy.

Dimensions of variation between DHBs included:

- whether the membership included disabled community representatives;
- the initiative taken by the Committee relative to the Board;
- the breadth of functions performed;
- the degree of auditing and monitoring undertaken;
- the engagement with the wider community; and
- whether mental health was included within the DSAC domain.

#### **Case study A**

The DSAC (A:17-18) in this DHB met four times a year. The membership consisted of Board members with two appointed disability community representatives, although one later resigned. The position was left open until after the forthcoming election. Appointment was by advertising, asking suitable people to apply.

The role of the Committee was described as having input into the development of disability services, some advocacy, auditing access issues, monitoring, reviewing HR policies around the employment of disabled people in the organisation, and improving liaison with a provider of equipment for the disabled.

The workload of DSAC was described as “*light*” compared to the other statutory committees. One informant was disappointed DSAC did not engage with the disability community, did not assess priorities, nor did it evaluate service performance. The input into the Board about the development of disability services was minimal and the Committee had no liaison with disability services.

The Committee unsuccessfully advocated for a more comprehensive disability needs assessment and for a disability workforce stock-take.

The work programme for the Committee was decided by the Board. One informant expressed the view that a disability representative on the Board and on each of the other committees would help ensure that perspective is taken into account.

#### **Case study B**

The DSAC (B:26-27) included a mixture of Board members and seven representatives of the disability community. According to an informant the seven external members provided a valuable two-way link between the Board and the disability community.

At the time of the first round of interviews DSAC was still waiting to be briefed to clarify its role. Board minutes (August 2003) indicated members were waiting on the devolution of funds for the older disabled before setting the DSAC work programme for the coming year, although its role in relation to mental health had been confirmed. It was agreed in December 2002 that the Committee would take the overview and lead responsibility for mental health. The role evolved over time and by 2004 the DSAC was more functional.

DSAC’s operated as a “*parallel and complementary influence*” for the implementation of the Disability Strategy. Other matters of interest to the Committee included mental health, the devolution of funds for the older people, home support, needs assessment and service coordination, the Health of Older People Strategy, and integrated care. DSAC also acted as a disability reference group for the Board, helped

develop policy in relation to disability matters and “*was engaged by the certification of residential homes.*”

An informant considered DSAC had successfully influenced the Board.

### **Case study C**

The role of DSAC (C:17-18) within this DHB was to advise the Board on the disability support needs of the population, the priorities for the use of disability support health funds, and to make recommendations on disability aspects of the DHB’s strategic plan, statement of intent and annual plan.

A major achievement of DSAC was the development of the Disability Strategy Action Plan which was audited quarterly. There was reported to have been good progress, particularly on disability workforce issues. DSAC has had a “strong focus” on how the provider arm and mainstream services can be responsive to people with disabilities, and “a significant shift in this area is noted.”

The roles of the DSAC were summarised as:

- advocacy, to seek a culture change to make the DHB ‘disability –wise’;
- monitoring the Disability Strategy Action Plan, with discussions underway about widening the focus to include intellectual disability services and the DHB’s Disability Support Services; and
- engaging with stakeholders, including community agencies, consumer groups and the Ministry of Health..

The DSAC has evolved over the term in office. At the time of the first round of interviews, the Committee was perceived as “*marginalised*”, and was questioning its own roles and responsibilities. At the second round of interviews, mid 2004, some continued to question whether the Committee would exist if there was not the statutory requirement, and that the functions it served could be addressed through other channels. The alternative view was also expressed, that the Committee allowed an oversight and gave a higher profile to disability issues and services, which may otherwise have been disregarded.

It was concluded that the DSAC functioned well, was well-chaired and had “*carved a niche*” for itself. It both advised the Board and took responsibility for promoting disability issues. It was expanding the focus to also include younger disabled, and was holding some joint forums with CPHAC.

#### **Case study D**

DSAC (D:31) consisted of ten Board members and three community members, although this was criticised by informants because there were no representatives from the disability community. At the time of the second round of interviews the membership of the statutory committees was about to be reviewed. The Manager for the DHB’s Disability Support Services attended the Committee and also provided a monthly report.

The role of DSAC was defined as making recommendations that relate to disability support services to the Board, but guided by information and recommendations from management. The first task of the Committee was to identify the unmet needs in the community, which it did by meeting with a widely representative range of organisations. There were mixed views on whether representation was adequate, for example, one informant pointed out there should be more direct involvement of service users.

The function has evolved over the term in office. Before the funds for the older disabled were devolved, informants regarded the Committee as having minimal role, indicating the role was seen as intrinsically tied to this process.

Research informants pointed out strengths and weaknesses of the committee. The membership remained top heavy with Board members at the second round of interviews. The Committee was also criticised as being bogged down in operational matters and the interests of single stakeholders, rather than taking the strategic overview. There had been no discussion of whānau ora nor consideration of the needs of Pacific peoples. On the positive side, a community representative expressed appreciation of the accessibility of the committee and the ease of adding agenda items.

### **Case study E**

The DSAC (E:21) was reported as taking some time to become established. This was attributed to the later publication of the Disability Strategy and the delayed devolution of disability funding. At the time of the first interviews the DSAC was perceived as sitting outside the mainstream of Board activity, and that *“disability issues are a bit of an add-on to what we are doing”*.

The later developments of the DSAC were not reported on.

## **2.11 Committees Other Than the Statutory Committees**

### **2.11.1 Finance and Risk Monitoring Committee**

All five case studies have chosen to have an additional committee to oversee the finances of the DHB, monitor risk and to maintain an audit perspective on the organisation.

One case study (C:18) reported a Ministerial directive providing for payment to be made to members of such committees, signalling that there was Central Government recognition of the contribution such a committee could make. This had happened after DHBNZ and several DHBs lobbied for such a change, “to ensure best practice in governance.” Some informants considered such a committee should be included in the NZPHDA statutory requirements.

In this DHB the financial oversight and auditing committee was reported as having three functions:

- Financial monitoring, by overseeing the robustness of the financial component of the DAP.
- Risk analysis to identify and monitor the highest sources of risk. The quarterly reports are also used for the monthly report to the Ministry of Health.

- Auditing the financial position, to strengthen governance level input into managing over-spending.

A second DHB (B:27) delegated authority to a committee with audit, management of risks, and monitoring functions. This committee considered the resourcing implications of the recommendations generated by the other committees, therefore working as a coordinating committee. This was also the domain where Government representatives discussed financial matters with the DHB. Initially this committee was attended by the Chairs of the other committees and was open to the Board, but not to the public. Over time the purpose of the committee clarified and the membership became more defined: three or four Board members, the Chief Operating Officer, the CEO and one or two external members.

A third DHB (A:16) included quality and financial auditing within the functions assigned to its equivalent committee. There were separate sub-committees to deal with hospital and financial auditing.

A fourth Board (E:22) took care to appoint an independent chair to their audit, quality and risk management committee to ensure an independent viewpoint, thus giving greater protection to the Chair and to the Board. In this DHB, the committee agenda and minutes went to all Board members on the basis that all Board members have to take some responsibility for the financial situation.

In the fifth case study (D:32) the equivalent committee incorporated both quality and risk dimensions and performed the following functions:

- managing risk with regard to financial and clinical risks;
- ensuring effective and reliable financial reporting;
- checking compliance with laws and regulations;
- preparing for auditing; and
- monitoring all fund allocations.

One informant saw this committee as “*absolutely essential*” while dismissing the statutory committees as a “*load of rubbish*”. Another informant saw this committee as central to managing the DHB but commented that the full Board was not always aware of what they were doing. Membership consisted of five members from the Board. The financial controller, the CEO and internal auditors also attended.

### **2.11.2 Other Committees**

Other committees were adopted by some DHBs. For example two had Remuneration Committees; two had Facility Development committees which oversaw building and development programmes; one had a Strategic Communications committee, and so on. These were not researched within the case studies.

## **2.12 Costs and Benefits of Statutory Committees**

In the first round of data collection most case studies reported that some informants questioned whether the benefits justified the costs of running the statutory committee meetings, or alternatively, reported review processes as the Board concerned strived to maximise efficiencies. However by the second round most informants considered benefits outweighed the costs overall.

The benefits specified were the advice given and the working through of issues in more depth, therefore saving the Board that effort. Other benefits acknowledged were the further opportunities for democratic participation, more robust debate, and the enhancement of the community perception that their interests were being looked after.

The costs incurred were management time and resources to service the committees with reports, time taken attending meetings, and conducting follow-up work. There were also financial costs incurred through payments to individual committee members.

One informant suggested the costs should be regarded as the price of democracy and transparency.

The DHBs made various efforts to reduce the costs:

- Chairs of statutory committees meeting frequently to avoid duplication.
- Reviewing work plans to streamline pathways of papers from Committees to the Board and reducing the double handling of issues.
- Each Board member being on two statutory committees to increase discussion and communication between Board members.
- All Board members also being members on all statutory committees, and all meetings held on the same day to reduce costs. However this was found to limit the benefits and a review was underway.
- One DHB initially combined HAC and CPHAC but then separated these meetings to meet statutory obligations.

## **3 Strategic Decision-Making**

### **3.1 Context**

The Minister of Health and the Minister for Disability Issues are responsible under the NZPHDA for the over-arching New Zealand Health Strategy (NZHS) and New Zealand Disability Strategy (NZDS) to provide the framework for the Government's overall health sector direction (s. 8). The Health Needs Assessments (HNAs) are to be conducted to inform District Strategic Plans (DSPs) (s. 38 (3a)). Community consultation on the draft DSP is mandatory under the Act (s.38, (3b)). The DSP states the objectives of the DHB for the 5 to 10 year period from the time of determination, and are to be made publicly available, as are any amendments. These plans are to be reviewed at least once every three years.

In order to recognise and respect the principles of the Treaty of Waitangi (s. 4), DHBs must establish and maintain processes to enable Māori to contribute to strategies for Māori health improvement, foster the development of Māori capacity for participating in the sector, providing for the needs of Māori and providing relevant information to Māori to meet these ends (s.23 (d), (e), (f)).

The first round of research mapped the process of the DHBs in meeting these strategic decision-making requirements, while the second round of research followed themes identified in the first round: the streamlining of the planning process, how the prioritisation framework has been applied, the influence of the 'centre' in decision-making, and progress on key goals.

## 3.2 Health Needs Assessment

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

The first Health Needs Assessments (HNA) of the local populations in 2001 was undertaken in a very tight time-frame soon after the DHBs were established, and was recognised as only a start in understanding the health status and needs of the communities. These processes were facilitated by the Funding and Planning divisions of the DHBs and were seen as an early priority of the Boards. As one case study informant stated, this was a “*fundamental*” first step in informing both planning, as formulated in the District Strategic Plan (DSP) and District Annual Plan (DAP), and priority-setting.

In the first round of planning, the three larger DHBs amongst the case studies conducted their own HNAs whereas the two smaller DHBs were included in a generic process undertaken by the Department of Public Health at the Wellington School on behalf of twelve DHBs throughout the country.

The generic process of the two smaller DHBs identified key gaps and areas of deprivation to inform the planning process. Although this was a pragmatic solution to meet the Ministry requirements, given the time constraints, it was described as “*broad brush stroke*” and informants from the two case studies using this process commented that it was only of limited value as it did not make transparent the data the assessment was based on. It was described as a “*missed opportunity*” and informants from both these case studies lamented the lack of data specific to the district, particularly for primary care, mental health and disability services.

At the time of the second round of HNA, one of the smaller DHBs (A:21) used a template developed by the SSA which made explicit the population health data relevant to the purpose and how the data was analysed. It was also hoped to include disability needs assessment, but some difficulties were experienced in getting data

from ACC. Based on the HNA, the Board identified four priority areas for investment: cancer, diabetes, cardiovascular and respiratory problems. The other smaller DHB (D:51) worked with its PHOs to generate ongoing HNA from the primary care data. As one informant stated, this would allow “*real time HNA*” rather than just every 3 years. In this DHB oral health, smoking, child car restraint and asthma were highlighted.

Various processes were used by the three DHBs conducting their own HNAs.

In one case study (E:25) the DHB undertook a thorough survey which gave detailed information on the DHB’s population and also gave “a more fine-grained picture” of the district’s ageing population, changing demographics, and the growth of Asian and Pacific peoples. The cost of this process was estimated to be approximately \$300,000, but was considered justified because of the importance of establishing a baseline for later comparisons. Informants noted “difficulties in getting accurate and useable primary care data.” The HNA identified cardiovascular disease and diabetes as priority areas for attention.

Another case study DHB (B:35) published their HNA in March 2002. The HNA described the District’s populations, mortality patterns and their use of personal health services. The development of the HNA relied heavily on two reports prepared in 2001 by existing community networks within two sub-districts. It was intended to inform all stakeholders, including the Board, providers and the community, and the DHB’s first strategic plan. Some gaps in services were identified, including within disability, mental health, maternity, outpatients, and primary care. Since then an ongoing process of needs analysis has been established as part of the work of the Funding and Planning team, reporting to the Board every six months. A revised full HNA was completed for the incoming Board after the 2004 elections. Informants were generally very positive about the usefulness of this process for identifying priorities and providing the evidence base to address inequalities.

The third DHB (C:27) to develop their own HNA regarded this to be an early priority for the Board and employed two planning analysts to assist the Planning and Funding team for the purpose. An external reference group also helped to inform the planning

team. The reference group included representatives from the City Council, Māori, IPAs, School of Medicine, and other community experts. The preparation of the HNA was seen as a fundamental first step in the strategic planning process. Although at the time informants reported considerable energy and resources were invested in the process, and that “information from a wide variety of sources was collated to inform the HNA,” in hindsight the initial HNA was regarded as “only a start in understanding the health needs of the community, partly limited by the tight time-frame in which it needed to be conducted.”

This DHB’s process for the 2004 HNA was more considered and, in the opinion of the researchers, resulted in “a well presented and research-based document featuring the Government’s health gain priority areas.” The HNA was expected to increase understanding of the community for many social service and health agencies as well as the Board. There were also reported benefits of working with other agencies and alignment between the DHB and the City Council long term community plan. The DHB combined a global view with specific assessments in priority areas, working with the SSA and adjoining DHBs on joint data gathering, and with IPAs and PHOs to collect primary care data.

In summary, all of the case study DHBs found the HNA process invaluable in guiding investment decision-making. The ongoing HNA was also seen as the means to monitor progress.

Common themes to the discussions on the HNAs were noted to be:

- the learning process involved as the Funding and Planning teams applied themselves to the task, and the subsequent building on earlier information gathered;
- that the exercise was crucial to informing prioritisation and giving a baseline for later comparison; and
- that the exercise highlighted gaps in the availability of some data.

The first round was limited to the data available, which in most cases was hospital data, secondary acute treatments and primary care data already recorded to monitor national initiatives such as Well Child or Adolescent Oral Health. After this starting point, all the DHBs set in place more proactive data collection aimed at filling the gaps in data, particularly requiring PHOs to supply ongoing data.

Whereas the NZHS was seen as setting the overall strategic direction, it was recognised that the health goals from this document might not be as relevant in some DHBs as other 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.

### **3.3 Strategic Planning**

#### **3.3.1 *The Process of Planning***

After the HNA was completed, the Board needed to establish a process for the development of the strategic plans. The DSP indicates the direction of the DHB over the next five to ten years, and should reflect both the HNA and the national health strategies, whereas the DAP focuses on the upcoming year and implements the larger strategic plan into specific actions for that period.

One case study (B:36) reported some informants expressed tension over the “plethora of documents” which the Ministry of Health required the DHBs to submit for sign-off:

- Health Needs Assessment (HNA),
- Statement of Intent (SOI),
- District Strategic Plan (DSP),
- District Annual Plan (DAP), and
- Crown Funding Agreement (CFA).

These were considered to blur accountability and strategic planning requirements.

One informant described the articulation of the DSP, SOI and DAP as a “*disconnected muddle*”, involving the DSP as general goals rather than a Strategy; the SOI developing from the DAP rather than the DSP; and the DAP beset by the internal politics of the Board and extreme compliance requirements by the Ministry of Health.

One informant pointed out the DSP is an accountability document to the people of the district, yet the Ministry required the DHBs to submit it for scrutiny, within an unrealistic time frame. The DAP as the business plan for the DHB is the accountability document but the elected members wanted to see it as an accountability document for the district electorate.

The DAP was also problematic in a second case study (E:26) which noted the difficulty of translating 5-10 year strategic priorities into the DAP as the organisation’s business plan, particularly “specifying deliverable strategic objectives while dealing with a tight funding environment.” In the latter case study, the 2002-2003 DAP sign-off was delayed due to the projected deficit. While eventually resolved by negotiation, the delay in formal approval of the DAP, and the DSP as a consequence, meant the strategic plans were at risk of being out of date before actually being released.

The case studies varied in the degree to which management or the Board guided the planning process. In one Board (C IR:20) the draft process was signed off by the Board and statutory committees before proceeding, and the committees were consulted at each step. In another case study DHB (A:22) management appeared to have the primary influence on the planning process. A third DHB (E:26) acknowledged that the second round of planning had become more sophisticated and that the Board and senior management were planning together, although one informant noted the senior management held some concerns that planning processes should not become “*routine*” or “*short of critical insight*”, suggesting a desire by management to retain a guiding influence. There was also variation in the stage at which tangata whenua were involved.

One case study (C IR:20) described the first strategic planning process as “*daunting*” but worthwhile. It was noted that an effective database had been developed for future strategic planning and the learning that had taken place would enable the DHB to be “*a lot smarter*” in subsequent planning cycles. These comments are representative of the five case study DHBs.

Whereas the five to ten year time frame of the DSP allowed DHBs some latitude to set goals which reflected both the national objectives as defined by the NZHS and the locally identified priorities determined by the HNA, translating this into an achievable action plan for the forthcoming year, while remaining financially responsible to Government was difficult for some Boards.

### **3.3.2 Role of Government Strategies**

It was generally understood that the Minister and Government expected the DHBs’ strategic planning to be consistent with the aims and objectives of the New Zealand Health Strategy. Most of the case studies found a convergence of the national priorities and the local needs identified within the HNA.

Some case study DHBs found that reconciling the NZHS with community feedback and prioritisation was challenging but not unmanageable. One case study (C IR:20) acknowledged the value of the NZHS as being “evidence-based and research-led.” Another case study Board (D:36) perceived the HNA as giving the evidence-base to justify the ordering of priorities within the NZHS’s objectives and, if necessary, to highlight other identified local health needs.

The PHCS was considered particularly influential. One case study (E:27) noted “the centrality of the Government’s PHCS and the DHB’s response to it.” Informants in this DHB were “*unequivocally supportive*” of its intent and there was a perceived commonality between the Ministry and DHB primary care priorities. Another DHB (A:31) drafted their own strategies for Primary Health Care and Referred Services, both based on the Government’s PHCS.

One case study (D:38-39) reported viewpoints echoed throughout the other case studies:

- There is widespread support for the philosophical thrust of the strategies but some scepticism about the lack of resources for implementation.
- There are too many strategies.
- The DHB has only limited power to have an impact because of the inter-sectoral determinants of population health. With reference to the NZHS, one informant said *“there’s a certain irony that the word poverty doesn’t appear within the entire document”*.

### **3.3.3 Constraints on Planning**

In the first round of planning the tight timeframe and the poor synchronisation between documents acted as constraints. For example, in the first year the DAP preceded the DSP whereas the annual plans should logically flow out of the longer term strategic plans. Historical decisions were inevitably the initial major influence. One senior management informant (E:28) stated *“the picture is still very much fixed”*. Any changes were only marginal and therefore the role of district plans in the re-allocation of resources was limited. Those DHBs without deficit, or who were able to free up funding, were better positioned to fund initiatives at the margin in their identified strategic areas.

Other constraints to strategic planning were raised by various informants:

- local providers may lack the capacity or capability to implement new services;
- existing contractual obligations;
- inadequate information on existing contracts;
- workforce shortages;
- a lack of funding to act on identified priorities in those DHBs with a deficit;
- unexpected cost increases;
- the lack of a fully operational prioritisation framework;

- the amount of business from the Ministry limiting the capacity of the Board for strategic thinking;
- Ministry of Health requirements and national strategies over-riding local decision-making;
- tension between central and local priorities;
- the ‘culture and power’ of the DHB’s provider arm;
- ‘change is slow and cumbersome’ because of the time taken by the planning cycle due to the nature of the Board, the community consultation process and Government processes;
- the lack of ethnicity data (noted as a constraint in three of the five case studies);
- the lack of data to help strategically target interventions constrained the ability to address inequalities, despite the commitment to do so;
- the continued ring fencing of the Blueprint mental health funding was perceived by some as constraining innovation, the ability to be more responsive to local needs and to move towards more outcome oriented contracts;
- regional collaboration is needed to resolve some service sustainability issues; and
- involving Māori too late in the planning and decision-making processes.

### **3.4 Community Engagement and Consultation**

Boards and their DHBs used various methods of engaging with the community:

- maximising openness of Board and statutory committee meetings;
- taking these meetings into community settings;
- consultation processes;
- community networks or reference groups developed for particular purposes;
- focus groups; and
- by holding hui and public meetings.

All case studies indicated there was a learning process as DHBs and Boards clarified the purposes of consultation and how to best achieve these objectives. Issues that have needed clarification included what consultation should be used for, and where it is not appropriate, who needs to be consulted with, and the best methods to use. It was apparent consultation is not straight forward and requires a lot of effort to do well.

Across all case study DHBs, consultation and community engagement were considered to have multiple purposes, including gauging public opinion, as a reality check, to educate, to engage people to take more ownership of issues, to gain input into strategic planning, and to empower people. Some informants also considered community engagement to have led to a *“much more positive attitude by the community in the DHB environment”* and that it brought the DHB and community closer together.

Some disadvantages of consultation were noted: raising expectations; not all views can be accommodated which means going back to the community and explaining the outcome of consultation; and that it slowed down the decision-making process.

The nature of consultation in each of the case studies has partly been shaped by the pre-existing community networks. Some areas already had well developed health stakeholder group networks which the DHBs processes were able to build on or merge with, whereas in other areas the DHBs attempted to generate networks.

#### **Case study A**

One DHB (A: 28-31) used wide ranging methods to engage with their stakeholder groups: open Board and committee meetings with opportunity for the public to speak, public forums (quarterly during 2004-2005), an internal DHB newspaper, media releases, meetings involving the Board Chair and senior management with various stakeholder groups, inter-sectoral consultation, and consultation processes over strategic plans or service changes. These included focus groups with demographic sub-sets of the population or service groups, and a series of cluster hui to consult with Māori.

The DHB has more recently developed policy guidelines on consultation to inform the public about expected processes and the purpose. Consultation was seen to be an information gathering exercise, while the Board retained the decision-making, which may be against public opinion on occasions. Using the consultation process to educate the public about the wider issues was seen as one way of managing conflictual issues. Within this DHB consultants were used to facilitate the consultation on some more substantial service changes.

The gains from consultation were perceived to be greater community trust, better understanding of health matters by the public, and more constructive relationships with media due to the greater transparency of DHB proceedings. There was also increased community ownership of some major service changes and one PHO may not have proceeded without the strong community advocacy.

Some difficulties were also noted, including the need to educate the public on the distinction between consultation, as information gathering, and negotiation. It was expected that community engagement would continue to grow as people became more knowledgeable about health and health services.

### **Case study B**

A second DHB (B:42-44) reported more mixed views about consultation, although informants were in agreement that the process is not straightforward and requires a serious commitment of effort. The DHB initially struggled with changing the culture of the organisation “*so the DHB focussed out on the community and not inwards on its own organisational processes*”; the multiplicity of community views; the legacy of past consultations which had been poorly done; and a low level of trust among communities. The consultation on the DSP followed immediately after a lengthy consultation process on a major service development which meant the public were already “*consulted-out*”. Input was sought through public consultation meetings and through existing community networks in part of the district, or the reference groups linked with these networks. Early in the DHB’s existence, the community consultation manager sought links and coalitions with spokespeople in non-health sectors who gave a different perspective from the DHB. A team within Funding and

Planning analysed the consultations, doing “*a kind of translation job*”. Notes and summaries were fed back to consultation participants, and those making submissions were given a letter and newsletter. Later in the research period the DHB favoured attending already existing community group meetings. For example, the Chairs of CPHAC and DSAC attended some groups, such as Grey Power, and by mid-2004 senior management representatives were meeting quarterly with NGO networks.

With regard to the question “what difference does input make?” opinions were mixed, but some changes to plans at the margins were noted. Informants also considered that the interaction with the community clarified values. Some Board members found the length of time taken by formal consultation process frustrating. Over time the preference for “engagement” rather than “consultation” strengthened. Engagement was perceived to be about building trust and ongoing interaction, to link the DHB’s planning processes into communities and to be open to influence from the community. Community representatives noticed a change in style of consultation over the period of the DHB’s existence, with a trend away from DHB representatives just giving information towards more openness to listen.

An example of the potential pitfalls was given: a meeting with Pacific peoples was set up for a time and place when there was no bus service in that area, whereas it would have been preferable to ask the people to suggest a suitable venue.

### **Case study C**

The third case study DHB (C IR: 20-22 and C:28-29) took a proactive approach by aiming to up-skill all DHB personnel in community engagement so that it became “everybody’s business.” Board staff reported the Ministry of Health guidelines on consultation were informative and helpful. Engagement was seen as the overarching aim, and incorporated both participation in the planning process and formal consultation on the strategic plan. Engagement with the community also occurred through the statutory committees, presentations of various community groups to the committees, input from stakeholder groups into service plans, community input into PHO development, and stakeholder workshops as part of the strategic planning process. It was noticeable in this case study that consultation was targeted at specific

stakeholder groups, although the level of public interest in PHOs and land sales resulted in wider consultation. The DHB regarded this positively.

With regard to the community engagement with the statutory committees, there were very mixed views about its effectiveness. Community members on HAC were seen as having little impact whereas community representation on CPHAC and DSAC were seen as enhancing the knowledge, breadth and decision-making capability of these committees. Community presentations were valued, especially to CPHAC. However one informant stated managers were anxious that community input should only be on the existing work plan, rather than the committee forum being perceived to be a lobbying opportunity to change priorities.

Service plans have been developed with input from relevant stakeholder groups. Consultation processes on the strategic plans were conducted via a stakeholder workshop. These gatherings, held November 2003 and December 2004, were also used to gain feedback on the DHB's performance to date and the core direction, and to give opportunity to raise issues relating to the next planning round. Stakeholders included DHB clinical and administrative staff, as well as community health provider representatives.

#### **Case study D**

In this DHB community engagement was regarded as of central importance by some informants, as the feature that distinguished the DHB model from previous models of health delivery, and *“as a necessary counter to the clinical and economic leadership that cuts across the Māori view”*. Within this DHB the meetings were very open and transparent to all stakeholder communities. In addition, the Board meetings were held in various community locations to make them more accessible to the public; and hui and other public meetings were held. Some changes to the DSP have arisen from this consultation process.

At the first round of interviews there were mixed views about the consultation processes. One informant suggested that the coverage was not as proactive and wide as desirable, and that those who made the effort to participate usually had an agenda, which then skewed the picture. However after the second round of strategic planning,

some informants in this DHB considered the community was generally more aware of the Board's activities because of the openness. A number of recent examples were cited where the Board had modified decisions or re-considered aspects of an issue after feedback from the community. The researchers reported widespread approval of the accessibility to the DHB.

### **Case study E**

This case study DHB (E:27-28) "satisfied the requirements of the NZPHDA" for consultation on its 2002-2003 DSP and DAP. The Board received 59 written submissions, heard 13 oral submissions and held 17 consultation meetings. Although community groups and representatives concluded the DHB was committed to meaningful consultation, informants from both sides questioned the outcomes of the process. A DHB informant stated "*the biggest thing we got back was that the document [DSP] is not very easy to read*". An informant from a community group thought that, while it was "*done with best intentions*", it was neither meaningful nor satisfactory and doubted that it "*actually achieves anything*". This highlighted the fact that the planning documents are required to address quite different audiences: the Ministry of Health, the community and the DHB.

The assessment by DHB staff at the end of the initial planning round was that the consultation process met the basic requirements but could be improved. In practice the researchers observed no significant development in community engagement in the 2003-2004 planning round. Although there were some marginal changes to the DAP and PHO strategy, a number of informants saw the engagement between the DHB and various stakeholders as minimal. For example a Board informant saw the negotiations with primary care providers as '*communication*' rather than consultation, and clinicians and non-DHB providers regarded DHB planning processes as "an 'in-house' exercise which they felt removed from." The researchers also noted that these providers had raised expectations of being more involved in planning due to the increased networking relationships which had developed over the time of the DHB.

This case study (E:30-31) highlighted that “there are multiple and conflicting ideas of just who the ‘community’ or the ‘public’ is.” The term ‘community’ can refer to consumers of health services, non-DHB providers, stakeholder networks of providers, local government and other community-based organisations, and the general public, each with different connotations of what an engagement with the DHB may require. The researchers in this case study observed the Board and management tended to mean different things when talking about the community. However by the end of the research period, there were clearer distinctions between input from providers, consumers and the general public. By the end of 2004, community engagement and participation had been channelled into decisions about within-service design and delivery, rather than strategic decision-making which required choices between services. This was particularly evident with regard to primary care.

### **3.5 Prioritisation**

All of the case studies needed to establish a process for establishing priorities, which usually involved making criteria explicit and ranking services under consideration. There was some variance between case studies on who conducted this process and what information was used, as shown by the summaries from each of the case studies below. A common theme to most of the case studies was that, in practice, funding was already committed and there was little scope for even marginal investment decisions. Other constraints were the need for cost containment to reduce debt, the lack of capacity amongst preferred providers limiting further investment in those services, and inadequate information for the analytical processes involved. Furthermore, the Ministry of Health may issue directives which constrain the freedom of DHBs to make decisions. Some Boards tried to set up investment funds to give scope for decisions at the margins and to enable innovation. Two DHBs noted that prioritisation decisions were “within service” rather than “between services.” One DHB argued in wider forums that “between service” decisions should be made regionally or nationally.

### **Case study A**

One DHB (A:22,27) was initially constrained in its prioritisation by the need to manage the deficit. At the time of the first research interview round, the expenditure was seen as “*pretty well committed*”, with reduction of debt being the overriding principle. Within this DHB Funders and Planners considered applications for funding against criteria before forwarding recommendations to the funding management team, then to the full Board, for sign-off.

By the second round of data collection, the DHB was more financially advantaged due to corrections made by the introduction of the PBFF. The priorities for increased investment were a continuation of previous decisions which were also consistent with national priorities. Areas noted as receiving extra investment were population health goals of disease prevention and health promotion, alcohol and drug services, consumer development, key disease states (such as cancer and diabetes), and the community health workforce, particularly through the PHOs. This DHB also placed a priority on research to monitor and evaluate whether the investments were achieving the desired impacts and their outcomes within the community.

### **Case study B**

Another DHB (B:39-41) developed processes for prioritisation but in practice found little or no marginal choice, so that the only prioritisation was within service areas where refinements were made. With CPHAC’s help, the DHB developed an explicit prioritisation framework to assist decision-making. This entailed scaling all the services and rating each service against publicly explicit prioritisation and decision-making criteria: effectiveness, equity, value for money, and achievement of whānau ora. Preferential funding was to be given to primary care, preventative care, areas to benefit Māori, Pacific and those with low income, and to limit resources applied to surgery and secondary care.

As part of the cost containment programme, decision-making was tightly controlled by the Funding Management Committee made up of senior managers within the Executive structure. There were mixed views about the contributions of this group according to informants from outside this group. For example, one saw it as providing a good prioritisation process whereas another saw it as creating another tier of

decision-making which was “sometimes divorced from hospital clinical realities.” The Quality Improvement Group also has input into prioritisation.

Other “complexities in prioritisation” were around contracting with Māori and Pacific providers, which required time and skill to build relationships and trust, and to work with the complex community dynamics, whereas the DHB perceived pressure from the Ministry for ‘*quick changes.*’ Inadequate hospital information systems also initially constrained analysis and forecasting. It was also observed by two informants that withdrawal from services was difficult because the Ministry’s approval was required. “*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.*”

Clinicians’ input into decision-making was made through service division managers who prepared a business case to forward to the General Manager or Hospital Management team, who then forwarded proposals to the Funding Management Committee or HAC/ Board for decision. One informant considered there should be systems for standardising clinical purchasing decisions, rather than those decisions being made at the ward level, but anticipated the introduction of such a scheme would generate conflict with clinicians.

### **Case study C**

A third DHB (C:30-31) adopted a Prioritisation Framework at an early stage of its existence. Effective prioritisation had been identified as essential at three decision-making levels within the DHB: at the level of the Board’s strategic decisions, to ensure policies and plans reflect national and local priorities; at the funding and purchasing decisions level; and in operational areas, where choices are required to be made between technologies and intervention processes.

A practical methodology to apply the Prioritisation Framework was developed and piloted. The DHB was assisted in this process by the appointment of a health economist. It was expected that ongoing prioritisation processes will involve both the Executive Management team and the Clinical Board. A Strategic Investment Fund was set aside to support prioritisation but, in practice, the fund was deemed too small

to meet all of the DHB's identified needs and there were difficulties deciding whether to fund services incrementally or whether to set it side to accumulate. Within this DHB the Clinical Board was expected to provide a channel for increasing clinician involvement in strategic decision-making.

#### **Case study D**

This DHB (D:52-53) had an explicit prioritisation framework to guide purchasing decisions but this was reported to be limited in its usefulness. For example, some services were ranked low, but in practice would never be cut, such as palliative care. The prioritisation framework was then re-defined as "a set of core decision-making principles." These are applied to each service under consideration for purchase and modification, generating a score out of two hundred. One informant estimated there was only about 1% of ranked services they would consider re-allocating, another estimated the bottom 5% and the top 5% were scrutinised. The prioritisation points ranking was used to inform a funding plan which was internally reviewed before going to the Board for approval. This funding plan spelled out the intentions for purchase from the provider arm and from the non-DHB providers. This priority-setting exercise was subject to community or stakeholder consultation. Although at the time of the Interim Report there had not been significant change in resource allocation, by the second round of research data, areas for increased investment were identified in anticipation of when funds became available.

#### **Case study E**

In the fifth DHB (E:28-29) Board members commented the link between planning and prioritisation was not particularly obvious. In the first round one senior manager stated '*the process is still very much fixed*' and that changes were only marginal. At this stage the primary focus was to identify where disinvestments could be made amongst existing contracts to reduce the deficit. The Board was seeking to reduce contracts by \$2.6 million. Six criteria were applied to all primary care and personal health contracts as part of a review process: acceptability to community and consumers; minimise impacts on service access for priority populations; minimise impact on priority service areas; minimise potential to generate higher costs through flow-on increased use of secondary services; avoid reducing services with demonstrated high cost-effectiveness; and focus on contracts where there is least

evidence of improvements in health outcomes. The DHB acknowledged there were considerable difficulties in carrying out this exercise; one informant described it as '*quick and dirty*'. The ranked contracts were presented to the Board with recommendations regarding which contracts could be considered for disinvestment. However, the main recommendation, to disinvest in some fertility services, drew a sharp reaction from affected consumers (E:19) and was vetoed by the Minister of Health (E:41). In a paper presented to the July 2002 CPHAC meeting, it was argued that between-service prioritisation should be handled nationally or regionally, and that the DHB did not have the data gathering or analytical capacity necessary for robust prioritisation processes. In this background paper prepared by management, it was 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' (p14), and that 'the constraints of the current operating environment make disinvestment decisions untenable unless there is political and national support'. The DHB, in discussion with other regional DHBs, then moved to a position of emphasising within-service prioritisation rather than between-service prioritisation.

By 2004, changes in funding arising from PBFF adjustments gave the DHB a more favourable position with regard to its deficit, which enabled "*a still very small strategic fund to fund initiatives at the margin*". However demand-driven services (emergency medical, pharmaceutical and laboratory) have placed pressure on prioritisation plans. For example in 2003 one hospital was providing acute services at a level 23% higher than specified in the contract.

## **4 Finance, Funding and Contracting**

Under the NZPHDA s.10 the Crown funds DHBs to provide or arrange for the provision of agreed and specified services. Under the Act, the DHBs are responsible to the Minister (s. 37) and must operate in a financially responsible manner (s. 41). This is defined in terms of each DHB endeavouring to maintain its long term viability, to cover all its annual costs from net annual income, to act as a successful going concern, and to manage its assets and liabilities in a prudent fashion. Accountability to the Minister includes following the direction given by the national framework of strategies and priorities, plus being fiscally responsible.

### **4.1 Financial Position**

All five case study DHBs were under pressure to reduce their deficits which were initially substantial for four of the DHBs and relatively small for one of the smaller DHBs. Over the three year period of the research, four of the five had achieved approximately break even point or, in one case, a small surplus. Two of these four had been significantly benefited from the shift to the population based funding formula (PBFF) which corrected previous under-funding.

One case study (C:34) described the new DHB under “severe pressure” with a deficit of \$23 million in 2000/01. Through “judicious management” and through some sales of capital assets, the DHB managed to break-even in 2003-2004. However both Board members and senior managers warned that the DHB would continue to have difficult times ahead, due to the combined impacts of the PBFF and trends in revenue, a “significant” operating deficit related to historical patterns of funding, the demand for services and the management of contracts, and risks arising from the devolution of funds for the older people with disabilities. The Board has sought to maximise revenue, achieve greater efficiency and effectiveness, and manage expenditure. The linkages between these projects and the framework for financial risk management and

strategy was made more transparent for the Board and public through two key documents produced during 2004.

Another DHB (B:51) has had a large deficit throughout the research period, for example, the level of debt in December 2003 was \$78 million. This DHB remains on “Performance Watch” monitoring status. The DHB was a ‘loser’, that is, was assessed as being previously over-funded, and also lost income through the reduction in inter-district payments arising from changes to tertiary service referral patterns with the introduction of the PBFF.

A case study DHB (D: 69) which was described as ‘slightly’ in debt was the recipient of strong pressure to achieve financial break-even point. For example, the CEO reported back to the April 2003 Board meeting that the Minister of Health was adamant there should be no deficit. The Ministry of Health required the draft DAP to be re-worked to remove a projected half million deficit as “an unacceptable result.” Informants referred to “*immense pressure*” and that “*it was bit scary*”.

A fourth DHB (E:40) also had operating deficits in the first two years after establishment but was able to achieve a break-even result by 2004-2005. Although some of this change in status occurred due to the PBFF correcting previous under-funding, it also reflected cost reductions. The 2002-2003 DAP noted “These numbers translate into hard service reduction/ reduced access realities.” The DHB attracted criticism from both sides during the research period as it continued to keep a tight control over its budget: from the Ministry of Health for moving too slowly, and from non-Government providers for placing too much emphasis on its financial position.

The DHB (A:32) with the small surplus, having benefited from the introduction of PBFF, noted the change in financial status has been acknowledged by the Ministry of Health shifting them onto “Standard” monitoring with its associated reward of early payments.

The impacts of having a deficit, or feeling the pressure to reduce it, were described as considerable by all of the DHBs. One report (C:42) described the presence of the deficit as “the backdrop for all decisions surrounding finance, funding, and contracting,” with one manager stating “*its an obsession for us*”. Another case study report (E:41) quoted an informant as saying: “*It’s sort of like the elephant in the middle of the living room really, sometimes we manage to step around it but it’s just there hugely*”. This description of how preoccupation with deficit dominates any strategic thinking was consistent with the other case studies. Even informants from the DHB (A:32) with a small surplus described needing to overcome the legacy of the deficit thinking, stating “*money becomes more important than people*” and “*we can’t just sit there paralysed with fear*”.

## **4.2 Population Based Funding Formula (PBFF)**

The intention to fund DHBs using a population based formula was signalled by the Minister of Health in February 2001. According to the Minister, the aim of the PBFF is

*“...to fairly distribute available funding between DHBs according to the relative needs of their populations and the cost of providing health and disability support services to meet those needs.” (King, 2001)*

The details of the formula and the three year funding pathway was made known to the DHBs in mid 2002, with the roll-out of funds beginning in December 2003. Having a known funding envelope was considered preferable for planning purposes compared with negotiating individual service prices. The main issues with PBFF for the case studies focused on two themes: the level of funding and inter-district flows (IDFs).

The formula on which the population based funding model is based is intended to reflect the relative size and needs of the population. How well it does this, however, depends on the weighting placed on various adjustors and relies on accurate data for the district. The re-assessment of need prompted by the initiation of this process also revealed historical “inaccuracies.” Two case study DHBs were deemed historically over-funded, thus were losers under PBFF, whereas two were judged under-funded

and therefore were advantaged by this scheme. Inevitably the viewpoints of research participants on PBFF were coloured by the relative outcome received by their DHB.

The adjusters to the funding by population size include the percentage of Māori, lower socio-economic status, rurality, and the number of elderly people. There is also a “tertiary adjustor” for those DHBs supplying tertiary services. This is in addition to the inter-district flow payments. However, one DHB was strongly of the view that this was inadequate compensation because tertiary centres tend to attract high need users into the district as residents, which deprives the DHB of the inter-district payments while causing ongoing higher costs. This DHB initiated negotiations with the Ministry to achieve a fairer allocation. Other concerns expressed included the potential for inequities arising where there is rapid population growth; districts with high numbers of immigrants who may disproportionately not complete the Census questionnaire and therefore not feature in district statistics; statistics not including fee-paying foreign students who are entitled to free health care; and whether areas with rapid change have accurate statistics on the ethnic mix.

During 2004 two additional funding streams were incorporated into the PBFF model. Funding for PHOs became part of the DHB budget but was already ring fenced and therefore not available for re-distribution. Secondly the funds for the older people with disabilities, including that for the long term care of the elderly, were devolved. While this devolution was welcomed by most DHBs, the level of funding has been problematic for many.

Inter-district flows were seen as a potential source of financial risk for both those DHBs supplying the services and those DHBs requiring services. Payments from other DHBs for services provided to their residents made a significant revenue flow for the DHBs with tertiary services. Concerns expressed were about the transaction costs; the need for careful monitoring to ensure IDFs are properly accounted for; accurately ascertaining the residential status of all patients presenting; and the perceived risk of other DHBs reducing referrals, thus reducing IDF payments, whereas the tertiary centre has sunk costs already invested in running that centre. The IDFs are part of a bigger and more complex picture: there are wider issues of

evolving patterns of service, supports for services elsewhere, and efforts to develop sustainable services across regions.

Despite the concerns expressed at the early stages of the PBFF, there was a trend towards acceptance of the model over the period of the research. It was recognised as a ‘commonsense model’ and as the reality with which the DHBs work. What it has meant for individual DHBs has varied depending on the financial status and the unique factors affecting that DHB.

One case study DHB (C:34-36) supported the PBFF system in principle and appreciated that the three year funding pathway gave some certainty for financial planning. However the Board and senior managers found the details were problematic, due to historical ‘over-funding’; their assessment that devolved funds for the older disabled were grossly inadequate; and a significant shortfall between the adjustor and the costs of providing tertiary services. IDFs were another source of concern. The Board’s approach was to carefully monitor to ensure proper accounting, for example, front-line staff ascertaining the residential origin of patients presenting. IDFs are also related to the regional development of clinical and administrative support to ensure all DHBs across the region have sustainable services. Informants reported that the management of the revenue aspects of PBFF required significant infrastructure within the DHB.

Another case study DHB (B:51-52) was also a ‘loser’ under the PBFF system. The 2002-2003 DAP predicted some changes in referrals through the IDF system, which “about 20% of the DHB’s turnover was tied up with.” The DAP warned that the DHB may need to increase its prices for tertiary services. At the end of the research period informants were “very concerned” about the downturn in revenue from this source.

A third case study DHB (E:43) had markedly improved funding after the introduction of PBFF in December 2003, after being assessed as having been significantly under-funded previously. The 'catch-up' funding was phased in so that the full equitable population-based entitlement will be reached in 2005-2006. By the end of the research period the additional funds had enabled the Board to move beyond financial survival to set aside a small amount of money to fund new initiatives at the margins in some of the more strategically important areas.

## **4.3 Deficit Management**

### **4.3.1 Sources of Financial Risk**

Depending on the circumstances within each DHB, Boards were required to manage financial risk while also applying strategies to reduce costs. The various sources of risk are collated here with reference to the number of case studies raising this concern.

All case studies were concerned about risks attached to the devolution of funds for older people with disability.

Four case studies expressed concerns about cost drivers which were not under the control of the DHBs, including the price of blood products, national pharmaceutical contract, the price of insurance, and the exchange rate.

Each of these concerns was noted by three case study DHBs:

- the amount devolved from the Ministry of Health was deemed insufficient to fully service existing contracts;
- provider arm not keeping to budget; and
- labour force costs, including growth in wages and salaries, costs of locums and changes to the Holiday Act.

Each of these concerns was noted by two case study DHBs:

- the demand for services being higher than the contracted amounts, with specific reference to services for older people, acute and emergency services, pharmaceuticals and laboratory services;
- changes introduced by the PBFF (both of these DHBs were found to be previously “over-funded” according to the formula, and therefore faced a reduction in funding);
- tertiary services insufficiently compensated for under the IDF repayment system; and
- the exchange rate and the rate of inflation.

Each of the following concerns was noted by one case study DHB:

- operating deficits related to historical patterns of local funding ;
- population growth in excess of that provided for under PBFF, leaving the DHB in deficit ;
- service growth as some services were repatriated instead of being provided regionally ;
- the high costs of locums due to problems in recruitment and retention of medical specialists, and the fact that locums are excluded from claiming ACC surgery revenue;
- public expectations on the hospital to introduce new technologies and improve the quality of services in terms of health delivery; and
- contracts not being delivered on (raised by one DHB informant although it was also stated that there were no current concerns at the time of interview).

### **4.3.2 Strategies Employed to Manage the Deficit**

The case study DHBs which inherited debt were under pressure to achieve the objective of zero-deficit within three years. All case study DHBs were concerned with managing the various financial risks to avoid incurring a deficit or worsening the balance sheet. All case studies scrutinised expenditure through internal organisational structures, such as their finance, auditing and risk management committee. The HACs were used to monitor expenditure in DHB provider arms.

Three case studies reported using collaboration with other DHBs as a strategy to reduce costs. Collaborations included purchasing commodities in bulk, brokering more favourable insurance terms, and achieving economies of scale.

Each of the following strategies was reported by two case studies:

- efficiency drives within the provider arms;
- securing the maximum revenue possible, for example, by ensuring adequate compensation for the provision of tertiary services;
- finding more effective governance and management arrangements;
- reviewing expenditure;
- Planning and Funding teams reviewing, rationalising and monitoring contracts; and
- the sale of capital assets.

Each of the following strategies was reported by one case study:

- reducing IDFs by repatriation of secondary medical and surgical services;
- engaging with clinicians to manage demand for services and find new models for service delivery;
- a cooperative risk management was conducted for the first year of the DHBs to manage demand driven expenditure, with all DHBs contributing to a joint pool which was used to pay the excess for those with cost blow-outs;

- “judicious management in non-clinical and corporate support areas” including improved energy, travel, and food prices and better deals on cleaning and telecommunications;
- disinvestment schemes through the use of explicit criteria; and
- the development of a workforce management information system to monitor labour resources more easily.

Organisational strategies were also employed:

- One DHB focused on achieving tighter synchronisation of management and governance approaches. Better coordination between management, the Board and the advisory committees enabled monitoring and managing perceived sources of financial risk.
- Regular reports from provider arms and demand driven services were used by most DHBs.
- One DHB incorporated senior clinical advisors from nursing and medical into the Executive Management team to achieve more ownership of financial risk management by the clinical staff.
- One DHB developed explicit criteria to review all the existing contracts as part of a disinvestment effort. In practice the recommended disinvestment that arose from this exercise was not acted on because the Ministry of Health overturned the Board’s decision. However the review did lead to some changes in specifications.

All of the case studies were keen to clear their deficits to allow consideration of more strategic discretionary spending. Those DHBs which were in deficit experienced pressure to achieve a break-even financial result from the Ministry of Health.

Other issues raised by single case study DHBs were as follows:

- One case study highlighted the poor quality of data and analysis supplied by services for the purposes of monitoring and decision-making.
- One case study reported an initial reluctance on the part of the Provider arm to accept the wider role of the DHB as purchaser of community based services. Some in the provider arm regarded the expenditure on non-DHB services as “*spending our money*”.
- One case study informant observed the preoccupation of the Board and management to be on adjusting to the structural changes and therefore not as focused on the financial management.
- One case study informant described the role of the Ministry as ‘*punitive*’ rather than supportive in relation to the efforts of the DHB to reduce their deficit.

One case study informant expressed the viewpoint their Board and Statutory Committees were there to create a perception of public responsibility for the financial risks. This was seen as politically expedient, rather than the health system actually requiring twenty-one health boards each with eleven people on it to run effectively. The informant’s view of this management of political risk was “*It’s very smart*”.

#### **4.4 Devolution of Contracts**

The initial devolution of contracts from the Ministry of Health and HFA occurred in June 2001. A second wave of devolution occurred in October 2003 when the funds for older people with disabilities were devolved to the DHBs. All of the case study DHBs reported considerable difficulties, with the second round of devolution generally regarded as worse than the first.

The first round of contract devolution was described as “*fraught*”, “*horrible*” and “*disastrous*” by informants in three different DHBs (C:39, D;72, A;34) One DHB (C:40) had expected the second round to go more smoothly but in practice all the

DHBs reported the second round was even more difficult than the first. Each devolution was followed by a process of due diligence which involved the DHB carefully checking each individual contract and identifying the areas of risk. Apart from this being a very time consuming process which stretched the capacity of most DHBs, there were a number of problems experienced by the various DHBs including:

- incomplete contracts;
- a lack of information to undertake due diligence;
- missing information on the management or correspondence history;
- inadequate funding for the contractual commitments (this was particularly acute for the second round of devolution);
- the contract terms were not well specified;
- inaccuracies in the contracts received, with a need to do a “*huge amount of checking*”;
- the legacy of poor monitoring under previous agencies and the Ministry of Health so that it was not clear whether providers were delivering to contracts;
- slow transfer of the contracts so that there was a period when there was an inability to access a copy of the contract while the DHB was already responsible for monitoring provider performance;
- a lack of information on the historic patterns of service use and expenditure trends, especially for older people;
- provider risks related to quality, health and safety issues because of poor monitoring;
- some responsibilities were transferred without the accompanying transfer of funds in relation to older people services;
- a lack of capacity within the DHB to undertake the processes required for contract devolution;
- HealthPac holding a different contract than the version that was actually signed; and
- the lack of any national training programme to prepare DHB personnel for the devolution process.

One DHB (D:72-73) was severely hampered by also changing regional grouping to a different shared service agency. Whereas the SSA retained some institutional knowledge and was able to act for other DHBs within the regional grouping, that DHB's contracting history was unknown. Therefore the SSA was unable to assist the DHB to overcome a period of being in limbo. During this period the DHB needed to approach providers to ask to look at their contract as they had no immediate access to records. This same DHB also was unable to access files for Māori health providers as the Māori Health Directorate 'refused to release them.' Another DHB however reported the contract transfer for Mental Health and Māori Health providers was smoother than for other sectors.

#### **4.5 Contracting Relationship and Negotiation**

The devolved contracts were either rolled over or re-negotiated as they came up for renewal. The quality of the relationship between the DHB as purchaser and the provider was seen as crucial to the success of the negotiation process.

One DHB (E:44) made a policy decision to initially roll-over all their contracts to give themselves time to build relationships and to bed in the new structures. The DHB also needed to build capacity to undertake the negotiations. However this had the disadvantage that some providers had already been deferred by the HFA for even simple adjustments to their contracts such as the price reflecting changes due to inflation. Furthermore, the devolved contracts were mostly price and volume contracts which did not fit well with population health objectives. Another DHB (C:40) developed relationships with providers through a series of stakeholder forums: a Mental Health Forum which was a joint meeting of the CPHAC and DSAC with mental health providers from both the community and provider arm; and Planners and Funders' meeting with community providers to explore progress on key strategic directions.

The perspectives of providers on the relationships with the DHBs were mixed.

One case study (C:40) reported generally positive reactions from providers, although it was also noted that several agencies “sought a more active approach from the DHB.” Other comments from non-DHB providers included that providers were concerned about the inadequacy of price increases in the 2004-2005 contracting round and that new contracts were not being completed before old ones expired, and in fact, there were some instances of NGOs operating without a formally signed contract “for some months”.

A second case study DHB (B:52-53) also reported providers were concerned about contracts not being negotiated in time, which meant a lack of time for local input (in the case of a PHO). Both providers and DHB personnel were dissatisfied with annual contracting which was perceived as preventing longer term planning and as creating an environment of instability and unsustainability. NGO providers considered the DHB did not understand the realities for small providers, including the gaps in their infrastructure and the way in which they were carrying the cost of living increases.

Another case study quoted one provider informant as saying the DHB (D:73-79) was ‘*dysfunctional*’ due to the lack of capacity. An early audit of the DHB (June/July 2002) highlighted a lack of clear and transparent processes around provider selection where services were contestable. Although DHB personnel considered there had been steady improvements in processes since then, providers expressed a range of concerns: that the DHB favoured their own provider arm, that the DHB was not objective enough to make purchasing decisions, that the DHB was “top-down” with uneven power distribution, that contracting was too rigid, and that the DHB was more prescriptive and “more hands on” as compared to the HFA. On the positive side, providers felt the DHB was easier to deal with because of the personal contact.

A fourth case study (E:45-49) found non-DHB providers held various concerns about the DHB, including the lack of auditing and review of existing contracts, the perception there is inequitable access to funds, a focus on inputs rather than outcomes, and the fear that the DHB will favour the provider arm over non-DHB providers. Initially the non-DHB providers experienced the DHB as “top-down” in

their approach and not sufficiently consultative. This DHB initially rolled over existing contracts which were criticised by providers as too long, poorly written, and not easily monitored or managed. By the second round of interviews the DHB informants reported they had been negotiating directly with individual providers and relationships were improved. This was confirmed by some of the non-DHB providers, but others still complained of a lack of negotiation; the contractual relationship was described as ‘fragmented, ad hoc and disjointed’; and the funder still had difficulty getting a grasp of what contracts existed and how they should be delivered. Provider informants suggested improvements such as better communication; acknowledgement of the increasing gap between the contracted price (left the same for a number of years) and rising costs; and a process by which such issues can be dealt with directly with the DHB.

Across the case studies, providers valued positive and constructive relationships with Funders and Planners with two way communication flow. Good relationships and trust were seen as promoting more flexibility in contract terms. Providers also preferred stability and certainty, with longer contract terms preferred over the prevailing annual cycle. Contracting on an annual basis was seen as preventing longer term planning and created an environment of instability and non-sustainability. One case study (E:46) noted that the DHB had extended the duration of some contracts, enabled by the increased certainty of the funding path under the PBFF model and the translation of longer term strategic planning into purchasing. Annual negotiation processes are more costly for both parties.

Two case study DHBs had some contracts managed by SSAs. Although this incurs some economic advantages for the DHB, it was seen as blurring accountability lines for providers and potentially hindering the development of constructive funder-provider relationships.

## 4.6 Form of Contracts

The two smaller DHBs used the contract template developed by the Ministry of Health, merely changing the price and volume for the local purposes. However both reports independently commented that the form of the contract was too rigid and too long.

One of the larger DHBs (C:41-42) was striving towards more flexible contracts so that larger provider commitments can be covered by a full contract whereas smaller contracts can be covered by letters of agreement. However informants were still frustrated by the cumbersome nature of contracts and expressed a desire for less legalistic and more outcome focused documentation. At the time of the report there was an intention to trial a local version. Although providers were also keen to move towards more flexible contracting, there was a dynamic tension between the desire for innovation adapted to local conditions and the wish to maintain national consistency.

Another case study (B:53) noted that where contracts were written by the Ministry of Health and DHBNZ, as was the case for some PHOs, then the contract form was presented to the sector late in the process with little scope for negotiating or local input. Within this DHB most of the contracts were negotiated by Funders and Planners with the guidance of a negotiation brief, a contract template and a strategic direction derived from the DAP and DSP, overseen by the DHB's Funding Management Committee.

This DHB (B:53) also developed an innovative approach to contracting based on bulk funding which enabled a mental health NGO to work with clients in a more holistic way by focussing on desired outcomes rather than specifying activities. The NGO informant said this development was made possible by developing a relationship with the DHB over a long period.

Informants from another DHB (D:79) identified a number of changes they would like to see to the contracting process:

- Shorter and more succinct contracts.
- Less emphasis on negotiating every last detail. It was noted that there is as much time spent on a \$50,000 contract as one worth \$1 million.
- Given the drive towards integrated care, contracts should also be integrated to reflect this.
- Reduce transaction costs.
- Make contracts more responsive and pitched to the needs of the service users.
- Use plain language.

#### **4.7 Purchasing or Providing**

Two case studies reported concern amongst non-DHB providers that the DHB would favour their own provider arm over other providers. One of these case studies (D:74) noted that an early audit (mid-2002) gave a poor report because the process of selecting providers was not transparent. Two non-DHB provider informants (D:73) expressed concern the DHB was favouring their own provider arm and one informant observed that the language used by Funding Managers indicated assumptions that the provider arm would be the preferred provider. The other case study (E:45-46) reported that CPHAC members varied between those who regarded the Provider arm of the DHB as just another provider and those who regarded their role as “a good employer” to look to the provider arm in the first instance. The researchers observed there were instances of contracts for services being moved into, as well as out of, the DHB throughout the research period.

A third case study (A:33) commented that there had been no observable trend towards making rather than purchasing services over the 2002 to 2004 period.

A fourth case study DHB (C IR:29) made explicit in its contracting framework that “contracting decisions will be evidence-based in terms of both health benefit and value for money and will not give any preference to the DHB’s own provider arm.” This case study did not report any provider informants raising concerns about this issue.

The fifth case study (B:42) gave mixed reports on this issue. One informant stated (in early 2003) “*we’re still very much looking at providing our own in-house services wherever possible*”. Later another informant reported the balance of ‘make or buy’ had basically not changed over the period of research, and that criteria had been developed to provide guidance to the DHB on this.

#### **4.8 Capital Development Costs**

The three case studies which commented on this issue all reported that the prices paid for services are assumed to include provision for capital, rather than it being negotiated as a separate item. However one DHB (A:34) noted that some joint facilities between providers and the DHB are funded, and occasionally seed funding is paid to providers to undertake exploratory work.

One case study (E:47) reported this to be an area of major concern for some NGO providers. The larger NGOs are more able to free up funds from other contracts to cover this, and others have used part of the new contract to buy or lease the facilities or equipment they need. However the smaller NGOs do not have the range of contracts to give these options. It was noted that there is an assumption that providers rent their facilities and lease any capital items but this does not suit all providers.

#### **4.9 Lead DHB Contracts**

At the time of the DHB establishment, some of the larger DHBs acted as lead DHB for contracts which apply in a number of Boards. The lead DHB is responsible for negotiating and monitoring contracts on behalf of other Boards so that the provider does not have to deal with multiple funders. Although this potentially offers efficiency savings, this system was noted to be problematic from a number of stakeholder viewpoints. Two reports (C IR:32, B:49) noted that the lead DHB has a

demanding level of liaison required, whereas non-lead DHBs have indicated they would prefer to do their own contracting. The providers concerned also preferred to relate directly to individual Boards, despite this incurring higher transaction costs.

Another report (E:46) noted the lead DHB holds the full contractual risk yet has little control over the use of services by the populations of other DHBs. There was disagreement between the DHBs involved over who held the decision-making power. Providers within this case study also experienced problems through lead DHB contracting as in the event of disagreements between DHBs over some of the costs, the whole contract was cancelled.

Although some lead DHB contracts persist, there has been a trend towards unbundling these and devolving back to the individual DHBs.

#### **4.10 Monitoring of Contracts**

With the devolution of contracts, the DHBs also inherited the legacy of previous monitoring regimes. There was widespread comment from both DHB and provider informants that the previous monitoring of contracts had been inadequate. A number of informants (C IR:34, D:79, 98) indicated that they wanted improved accountability processes, both to ensure services were delivered to those who needed them and to correct perceived inequities. Informants identified problems with monitoring at the time the DHBs were established, including:

- the poor quality of information on contracts;
- lack of clarity about whether the providers were delivering on the contracts at the time of devolution;
- the DHBs were monitoring providers on contracts they had not written; and
- anecdotal reports of providers reporting low quality data because it was known this was not scrutinised;

One case study DHB (E:49) conducted an initial review of all their devolved contracts, with the result that a number of contracts were found to be not being delivered on. In this DHB the monitoring of contracts was initially on quarterly reports on specified indicators, mostly concerning volumes of services and utilisation patterns. By the second round the DHB personnel were increasing both the contact with the providers to build relationship and also refining the reporting requirements. The providers interviewed gave a range of views, some confirming the improvement in relationship and monitoring but two complaining of the increased paperwork and associated cost.

Other DHBs also tried to change both processes and measures to make them more meaningful and appropriate for the DHB purpose. One DHB (A:36) requested workforce information to be included as part of the reporting requirements because of the importance of recruitment issues as a constraint on service delivery.

## 5 Devolution and Sector Relationships

### 5.1 Context

‘Devolution is the creation or strengthening of sub-national levels of government which are substantially independent of the national level for some defined set of functions’ (Mills, 1990). On the one hand each DHB is charged with setting priorities to ensure improved health status of its community, and, on the other, DHBs’ strategic plans must be consistent with the NZHS and the NZDS, with the aim of equity of outcomes across the country.

The theoretical literature suggests that devolution can lead to efficiency gains from better local decision-making and service integration, more democratic governance and greater community participation. On the negative side, it is also argued that there can be a loss of economies of scale and the potential for duplication and fragmentation. There may also be a reduction in equity of access and outcomes due to different sets of priorities leading to differences in the range, type or level of service available.

While devolution requires the development of appropriate vertical relationships for funding and accountability, it also provides opportunities for new lateral relationships between DHBs and other agencies. The emergence of local, regional and national relationships potentially promotes innovation and strategic alliances. This section, therefore, reviews both the general progress of devolution and the new sector relationships, including the implications for capacity and capability to manage the new arrangements.

## 5.2 The DHB and Ministry of Health Relationship

All five case studies reported that the devolution of decision-making to the DHBs as signalled by the NZPHD Act had been slower than expected by informants in the DHBs. There was a general consensus that DHBs would like more autonomy and responsibility. Local decision-making was preferred because of the greater knowledge of local needs, more timely decisions, and greater ownership of implementation. Most expressed frustration at the degree of involvement of the Ministry in operational policy setting at the district level. It was stated that there should be greater demarcation between DHBs and the Ministry.

There were mixed reports on relationships between personnel, with varied reports from informants within case studies and also variance between case studies. Most informants found relationships with individual Ministry staff very positive and helpful. In particular Account Managers were identified as having “excellent” relationships with DHB personnel and were now providing faster feedback. Some DHB informants also appreciated the technical expertise and guidance extended by the Ministry. One case study report (C:43) noted the information given by the Ministry is ‘soundly based’, and the Ministry is always forthcoming with templates, advice and information papers. Another (B:45) appreciated the willingness of the Ministry to send staff to provide briefings and presentations.

There were also some positive views expressed about the Ministry as a policy organisation. Some found the state of formal documents and agreements to be improving. For example one case study (B:47) noted that 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.” Another case study (C:43) considered the coordination between the Ministry and DHBs at national level has improved. There are now regular meetings between CEOs and the Ministry where CEOs can contribute items to the agenda. This was found to be an effective mechanism for dealing with issues.

There was a widespread view across all the case studies that the Ministry should be concerned with policy development and the overall monitoring but that the operational decision-making should be left to the DHBs. One case study (C:43) stated:

*“there was a general view that the Ministry had a large resource which had changed little and that it should downsize and shift its role from funding back to policy development, upgrading skills to reflect this change.”*

Negative comments focused in particular on what was perceived to be excess involvement by the Ministry in decision-making and monitoring. However these views were not consistent as illustrated by the more detailed accounts of the relationships and tension points from each of the case studies.

One case study (B:45-46) reported that the Board tended to experience the Ministry's presence more positively while management were more critical. It was also noted that the Board did not have as much contact with the Ministry as the Executive. One informant saw the Board as representing the Minister, *“it's a sort of bridge between the shareholder Minister and the ... public”*. Board members were appreciative of the ease of access of Ministry advice and two way communication. However, management informants were less happy with the relationship. While these informants named a number of “outstanding [Ministry] individuals who were excellent to work with,” there was considerable tension over the relative roles of the DHB and the Ministry. 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.”*

Other complaints were that:

- the Ministry is too involved in operational matters;
- the Ministry gives ‘*a mass of conflicting advice and requirements*’;
- the Ministry has not provided the national leadership required for tertiary services to ensure equitable access throughout the country ;
- there is a lack of capability within the Ministry to deal with 21 DHBs when it had previously been “geared up” to monitor only one HFA;
- the Māori and Pacific teams within the Ministry were invisible to the DHBs;
- the Ministry was too readily swayed by the “powerful GP lobby” with regard to the DHB’s primary care developments;
- the Ministry should offer more assistance and leadership on information technology, information management and technology assessment;
- the Ministry’s negotiation of the pharmacy contract was unsatisfactory; and
- the Ministry was “*overly and inappropriately involved*” in the details of the DHB’s operations.

Some DHB informants felt there to be a general lack of trust from the Ministry to the DHB, which one informant described as “*frustrating and demoralising*”. The main relationship with the Ministry was through the Sector Funding and Performance section of the Ministry which acted as the “filter and front and brought the aspirations of all the Ministry’s directorates to the DHB” arising from the 38 Strategies, each of which was driven by staff “passionate about their area’s aspirations.” The Sector and Performance Directorate played a role in the “checks and balances” attached to each of these. However DHB informants complained of different messages from the different parts of the Ministry. Despite these difficulties, all who commented were adamant the relationship with the account manager was excellent. Informants also all agreed that the relationship between the DHB and Ministry had steadily improved, helped by dialogue and continuity of personnel.

In a second case study DHB (E:55) there was considerable frustration over the lack of clear demarcation of roles between the DHB and the Ministry, and for “being accountable for policy implementation without having control over it.” The researchers saw “the DHB-Ministry of Health [relationship] as the main fault line of the tension between national policy and consistency and local responsiveness.” Other focal points for frustration were:

- the lack of devolution of decision-making, e.g. a decision to disinvest in fertility services was overturned by the Ministry of Health;
- the inefficiency inherent in the design of the system, e.g. the amount of DHB resources consumed by staff attending meetings in Wellington, and *‘you have got a lot of people in the Ministry working in their little pet silos’*; and
- the reporting requirements which were seen as excessive and designed for the Ministry’s purposes but holding little value for the Board’s objectives.

Despite these frustrations and the perception “on both sides of the relationship that the other side lacked good faith on occasion”, most management personnel and Ministry informants interviewed reported good relationships on a personal level.

A third case study DHB (C:43-44) reported that overall informants experienced good relationships with the Ministry of Health, with specific reference to the Ministry’s willingness to provide sound information and advice. National coordination had improved, relationships with the account manager were good, and feedback to DHBs had become faster. However there were some areas of tension:

- the devolution of funds for the older people with disabilities;
- the implementation of the PHCS;
- monitoring was considered excessive and to be increasing, and of little use for the DHB’s purposes;
- the lack of devolution of the public health funding;
- the lack of consultation with DHBs through the development phase of new policy initiatives;
- that ‘funding decisions are still politically and nationally controlled’;
- the Ministry did not seem to appreciate the risks for tertiary hospitals; and

- whereas the DHB was focussed of managing a deficit, the Ministry was felt to have shielded itself from making rationing decisions.

In another case study DHB (D:80-82) informants also reported positive relationships with individuals but described the overall relationship between the DHB and Ministry as problematic. The exceptions were the Māori provider informants who consistently reported very positive relationship with the Ministry and expressed a preference for central Government funding decisions which were felt to be more independent and less influenced by local vested interests. Informants who reported tensions complained of:

- the lack of devolution of decision-making, and interference in decisions made locally;
- rigidity from the Ministry of Health regarding some funds, for example, the ring fenced mental health “Blueprint” funds;
- service volumes dictated by the Ministry which may not match local need;
- the Ministry continuing to retain “tight controls” over the parameters of contracting;
- the inability to look at the “big picture” when the public health funds have not been devolved;
- a lack of consultation by the Ministry of Health on the health strategies;
- the lack of assistance on the planning documents and the HNA, and the tight time frames to prepare these, contrasted with the slow turn around from the Ministry; and
- the view that the health reforms were more about shifting blame, whereas the Ministry should take a more supportive role with DHBs in the media and to address capacity issues when they occur. This informant referred to a recent tragic mental health incident in Southland as an example where all blame was pushed onto the DHB.

The fifth case study DHB (A:37-38) noted mixed reports from informants on the quality of relationship between the DHB and the Ministry. There was general agreement that there had been a trend towards even greater rigidity over reporting requirements over time and that the Ministry continued to be “intrusive” over the duration of the research. Specific criticisms were that:

- the Ministry demands reports on time but does not provide timely responses to the Ministry;
- the lack of practical knowledge of the issues that the DHB faces or might have to face, with one informant stating “*I think there is a tremendous amount of ill-informed comment coming out of the Ministry*”;
- the reporting requirements which are of little use to the DHB but necessitate “*this enormous clerical infrastructure*”; and
- poor communication, for example, forewarning of Ministry visitors.

Informants expressed the hope that over a longer period the Ministry would develop trust in the DHB and award them more autonomy.

### **5.2.1 What Promotes Positive Relationships?**

The building of relationships was seen as facilitating positive and constructive interaction between the DHBs and the Ministry. Networking arises from the national and regional committees attended by both DHB and Ministry staff. This is helped by the previous knowledge of one another as individuals move around within the health sector.

Regular meetings set up between DHBs and the Ministry also promoted good relationships. In addition to the meetings of CEOs and the Ministry, one case study DHB (A: 38) set up six-monthly meetings which were attended by the CEO, the Board Chairperson, and the chairs of the statutory committees, as well as the Director General of the Ministry of Health, along with the Deputy Director General from the Funding sector of the Ministry. This meeting allowed participants to review matters of mutual interest and allowed the Chairs of the statutory committees to raise

emerging issues. It was reported that this led to a deepened understanding of key issues and the development of mutual respect for each others' roles.

Communication protocols which identified who should be contacted, for what purpose, were found (A:38) to be helpful in avoiding confusion and streamlining information flow.

The reporting requirements were regarded as excessive. Some DHBs expressed the preference for more streamlined and higher level reporting. National work on developing outcome measures was seen as valuable in working towards a smaller amount of higher level reporting rather than requiring details of performance on service delivery in all areas. The Ministry's leadership on this issue was commended by one case study DHB (C:44).

There was a strong preference expressed through the case studies for more clearly defined roles and boundaries between the Ministry and the DHBs, and then for the Ministry "*to let the DHB get on with it*" (D:83). Similarly, there was a theme of wanting the Ministry to devolve more local decision-making to the DHBs.

It was suggested by one case study (D:83) that the Account Manager and other Ministry staff should visit the DHB from time to time. Other case studies which have had more contact with Ministry personnel noted how helpful that had been in building constructive working relationships.

One case study DHB (D:83) noted the interface between DHBs and the Ministry has been streamlined by all the communications for the week arriving in one package on Monday morning.

### 5.3 Role of Clinicians

All the case studies observed greater involvement of clinicians with management than under previous models of health care. Three case studies have set up a Clinical Board as a conduit for input between clinicians and management. Most of the case studies noted that the underlying philosophical gap between clinicians and management has narrowed since the health reforms. However three of case studies observed there to be distant, or poor, relationships between clinicians and their Boards.

One case study report (C:53-54) noted that within that DHB there had been frequent comments about the need to engage clinicians in decision-making and to repair the “shattered relationships of the 1990s.” It was considered that clinician involvement can best occur through appropriate structures that recognise clinical concerns and allow them to be addressed. Over all clinicians were perceived to be more closely engaged in strategic and management work than under previous regimes. Within this DHB clinicians were involved by:

- appointing clinical directors to positions throughout the hospital;
- their frequent presence at statutory committee and Board meetings;
- the appointments of the Chief Medical Officer and an Executive Director of Nursing to the Executive Management Team;
- the Clinical Board, as a conduit through which the clinicians could air issues and to oversee clinical governance matters, and as a channel by which senior clinicians can have input into management and the Board;
- the “broadly-based Quality and Safety Council” which also provides a focus for clinical concerns; and
- the development of prioritisation approaches which are expected to provide tools for clinicians to participate more effectively in decision-making within their clinical area.

Another case study (A:49) has set up a Clinical Board as a channel by which senior clinicians can have input into management decisions. Management informants saw getting buy-in from clinicians as essential to developing services and to bringing the deficit under control. However a clinician informant vigorously rejected the notion that clinicians were oblivious to the financial risks and pointed out that clinicians were used to managing demand when it was higher than capacity, which inevitably involved tension between responsible resource allocation and their role as advocates for clinical need.

In this DHB the Provider Management team, which is the operational management team for the provider arm, now includes the Director of Nursing and a representative from the Clinical Board which adds a clinical perspective to financial decision-making. One informant considered there was still too much distance between the Board and clinicians although some other informants considered the relationship as positive.

In a third DHB (E:54-55:) management and clinician informants saw their relationships as positive and that the pre-existing gap has narrowed. However in the same DHB the relationships between clinicians and the Board were perceived as distant. A Board informant stated they were keen to have clinician input as “*when we have our strategic dollar I want the clinicians to come along*”, whereas a clinician’s perspective was that the Board preferred “*to keep clinical departments at a strategic arms length*”.

In a fourth case study DHB (D:27-28) the clinicians were described as being in a collaborative partnership relationship with managers, and as being advisory to both Board and management. This was applauded as a much more positive and constructive relationship than under previous health systems, and was directly attributed to the health reforms. The DHB also has formed a Clinical Board which all clinicians may attend and is responsible for formulating clinical policy. At one stage the clinicians were critical of spending decisions. The managers threw down the gauntlet and said “*okay, you decide with this [limited] money*” which proved instructive for everyone concerned and helped build respect between personnel.

The fifth case study DHB (B:32-33) has a legacy of very poor clinician-management relationships. There were mixed reports from informants on the status of relationships throughout the research period but the majority considered there to have been improvement due to the health reforms. Social meetings between senior clinicians and between clinicians and managers had helped consolidate a combined sense of purpose. This was seen as an urgent need as the DHB moved towards integrated models of care. However the relationships between the Board and senior clinicians remained of concern to many informants at the end of the research period.

#### **5.4 Devolution of Funds for Older People with Disability**

During the first round of interviews many informants were keen for the signalled devolution of funds for older people with disability to proceed. The advantages of devolution were perceived to be greater flexibility in service provision to meet the specific needs of individuals and reduced boundary issues between services.

The devolution of funds for the older people occurred on 1 October 2003. The key tasks for DHBs at this time were to check the devolved contracts for completeness of information and to identify any associated risk; to audit the funding devolved against contractual commitments; to gain an understanding of the issues around the aged care sector; and to build relationships with providers.

The three DHBs which reported fully on this issue all experienced major problems with the devolution process. Regardless of the different preparations undertaken, the nature of the difficulties experienced were relatively consistent. All three DHBs experienced considerable financial risk associated with the devolution.

Other problems noted by case studies included:

- contracts were missing detailed financial and historical management information, making it difficult for DHBs to manage contracts and to assess the adequacy of baseline funding;
- a lack of risk auditing prior to devolution in the previous funding regimes under the RHA, HFA, and Ministry of Health;
- inheriting provider risks on quality, health and safety;
- the DHB picking up a legacy of aggrieved providers whose contracts have not addressed significant issues;
- insufficient funds devolved to cover contracted services;
- additional volumes of services commissioned and prices increased just prior to the devolution, making the baseline information and funding incorrect; and
- the Risk Pool had not been finalised prior to devolution and was inadequate to meet the under-funding that occurred.

The Risk Pool was created by the Ministry of Health but required the cooperation of the DHBs. The intention was to provide a central fund to assist those Boards experiencing shortfalls. In practice it has been fraught with problems. The DSS risk pool of \$14.7 million was consumed in 2003-2004 deficits, leaving no coverage for the 2004-2005 shortfall. The Ministry suggested a re-allocation between DHBs of funding, but these discussions were still ongoing at the end of the research period with no agreement having been reached.

One case study (C:44-46) reported that the DHB had approached the devolution with confidence, given by then they already had experience of managing such a devolution process and had a systematic plan in place. This plan included:

- monitoring the risks associated using the Financial, Audit and Risk committee;
- appointing additional staff to manage the contracts;
- engaging the SSA to coordinate the auditing process;
- the contract managers building relationships with providers through formal meetings and individual liaison;

- reviewing the service implications with the help of the DSAC; and
- reviewing the aged care sector in the light of the Health of Older People Strategy (HOPS) to ensure the strategic direction of ageing in place is supported.

Despite this systematic plan, there were “major problems” associated with the devolution process, with one informant describing the financial implications as “*catastrophic*”.

This DHB responded to the realities of devolution by monitoring the risk through the DHB’s funding and audit committee; working with the Ministry of Health on the Risk Pool allocations; working with other DHBs to address issues raised by the devolution process; and acting strategically by containing the deficit and bringing forward the planned review of the aged care sector.

The shortfall of devolved funds was exacerbated by the introduction of the PBFF system which determined the DHB would be approximately \$42 million over-funded, with a “significant portion” arising from the devolution of funds for the older people with disabilities. To address this, the DHB “needs to move towards national consistency and equity of access to aged care services urgently” which means, in practice, reducing long term residential care and prioritising access to personal care support services.

However, at the time of interviews in late 2004, informants were still angry that “*such a situation could have been allowed to develop*”. Both Board and management informants expressed “*shock and outrage*” at what was seen as “*persistent Ministry mismanagement*.” The reactions of informants were perhaps heightened by the contrast of the thoroughness of their preparations with the ensuing chaos, despite their efforts. Discussions to resolve this were still continuing at the completion of the research period. A national work group, in collaboration with other DHBs, was formed in an effort to resolve the issues.

A second case study DHB (A:41-43) saw the initial goal as gaining an understanding of the issues around the provision of aged care, including contracting issues and the perspectives of providers. The devolution was described by informants as unsatisfactory due to the lack of risk auditing under previous regimes, and therefore one of their first tasks was *“having to clean up some pretty lousy auditing and monitoring and administration”*. Another informant referred to the transfer as being *“a can of worms”* which needed to be addressed, and that this was a poor start to establishing the funder-provider relationship. Other actions taken by this DHB included conducting a public consultation process to adapt the Health of Older People Strategy (HOPS) to local needs. The interface between the aged care sector and PHOs was to be guided by the DHB’s primary care sector reference group. The primary care targeted funding for the over 65s was expected to address the cost access barriers raised as an issue during the consultation process.

Another DHB (D:86-87) prepared for the devolution by calling together a working party which included representatives from DSAC, the community, and DHB Funding and Planning, with two parallel reference groups of service users and providers. The working party helped define the relative roles of stakeholder groups with the overriding objective of improving coordination between services to more adequately address needs. Within this arrangement the hospital is seen as just one of a number of organisations involved, challenging the perspective that the hospital is in a top-down role. It was recognised all these stakeholders have a role but there needs to be a clearer understanding of the relative responsibilities plus a process to manage disagreement. In addition focus groups were used to raise awareness of services to reduce access barriers. In common with other DHBs the devolution of funds resulted in *“significant difficulties”* which were summed up by one informant as:

*“We didn’t get enough funding, the funding was not devolved in the right mix between the DHB and the Ministry of Health, funding for people with caveats on their homes was not devolved from the start, the risk pool has not been finalised or agreed, additional beds were commissioned by the Ministry of Health before [the DHB] took over and they don’t have the funds for the increased bed days likely to result.”*

## 5.5 Other Disability Sector Issues

Two case study DHBs expressed some concerns about the split management of funding for people with disabilities. In one DHB (A:41) this was perceived as leaving the DHB in the position of carrying the risks of insufficient support and residential services for younger disabled people. Lack of capacity within these services creates pressure on the DHB-provided services. Those under 65 who have both health and disability needs will tend to be served by whichever service has the greater resources, rather than this being determined by what is clinically optimal.

The second DHB (D:85) expected there to be some boundary issues over the changeover between categories, particularly as those near-in-age demonstrate needs more akin to an older age group. These issues of access to services were likely to be heightened for Māori who tend to show age-related conditions prematurely compared with the rest of the population. Another DHB expressed similar concerns.

A national review of the aged residential care contract was still underway at the end of the research period. The review was to include canvassing DHB opinion on whether the content and price should continue to be consistent between DHBs.

One case study DHB (D:38) made the comment that the NZDS (and by implication the HOPS) were very constructive but there was a lack of resources for implementation, citing as examples the goal of ageing in place, yet the financial resources for home help permit only one hour per week, and the lack of respite beds.

In this DHB (D:86), a manager informant considered education would help staff to better understand the policy frameworks for disability and primary care around service delivery and had initiated an education programme accordingly. This informant commented that each community health organisation has a service plan outlining the organisation goals. In his view these should be reviewed at 3 monthly intervals to measure progress against the goals adopted from the NZDS and PHCS, to reinforce the strategic directions they offer and to make them more living documents.

This DHB (D:85) also highlighted the tension between the objectives of standardisation of service specifications and addressing local needs. One informant suggested that national consistency would be helped by more training and publicity.

There was a general acceptance across case studies that younger people with disability should not be seen through a health mind-set. Therefore there was no pressure to change the status quo and devolve services for those under 65.

## **5.6 District Health Boards of New Zealand (DHBNZ)**

Over the research period, DHBNZ moved through an establishment phase to a position of providing a focal point for DHBs to coordinate information sharing and action on key issues.

Processes referred to by the case study reports included both national and regional meetings for Chairs and CEOs. The regional groupings also allow Planners and Funders and other managerial personnel to meet with their counterparts. The monthly reports from DHBNZ are tabled at some Board meetings.

The advantages offered by the national coordination role of DHBNZ were noted to be promoting consistency across the sector, and allowing greater coordination and connection between the Minister, the Ministry of Health, and DHBs. For individual DHBs, involvement in DHBNZ allows them to “*get a sense quickly of what is happening around the country*”. For small DHBs it offers the opportunity to participate in working groups and networks on topics of concern. DHBNZ also takes up issues with the Ministry on behalf of the DHBs. The reports from DHBNZ allow Board members and others to keep in touch with a wider range of issues of policy and operational significance to DHBs.

Issues which have been the focus of DHBNZ activities include negotiations of multiple-employer collective agreements (for example the nurses collective agreement); developing the Workforce Development Framework; negotiating with the

Minister over the Pharmac budget; analysis and modelling; collating work on tertiary hospital funding issues; and negotiating the pharmacy contracting and the involvement of the Pharmacy Guild. Through the regional groupings, Planners and Funders have developed Operational Policy Frameworks and service coverage schedules. The regional approach was considered useful for discussing issues of funding, shared services, accounting systems, IT and insurance.

Despite the general consensus that DHBNZ had become firmly established and had gained the confidence of most stakeholders, some cautionary comments were expressed:

- One DHB (C:48) highlighted that there have been occasions when larger DHBs, which pay higher fees to support DHBNZ, have been out-voted by smaller DHBs.
- One case study report (C:48) noted that there was ‘an almost infinite amount of work’ that could be done by DHBNZ and that priorities need to be set more tightly.
- One case study (B:49) noted that the smaller DHBs benefited most from joint working groups, whereas the larger DHBs usually contributed most of the skills and resources.
- One case study report (D:92) noted tension in that Board, because they perceived DHBNZ decision-making as eroding their autonomy. This Board sought to be more involved in the collaborative decision-making processes.

Most case studies expressed both appreciation for the contributions of DHBNZ and also some caution that its role should not be over-extended. The following statement (A:50) is representative: *“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”*. For example, in this case study there were mixed views over the role of DHBNZ as a national negotiator of contracts because of the reservation that in reality the issues are often different between the DHBs.

## 5.7 Capacity and Capability Issues

The NZPHDA model required the 21 DHBs to have the capacity to cover the range of tasks previously provided by the centralised HFA. In addition the DHBs were charged with new objectives of community responsiveness. Some tasks were challenging because of the increased capacity required, now devolved to the 21 DHBs, whereas other functions, such as consultation, were previously undeveloped. Furthermore, the dissolution of the HFA and the establishment of the DHBs was a phase of staff movement. The case study research did not systematically research these capacity issues. However it was a theme that recurred throughout the reporting and underlay some of the perceived weaknesses about this model of health care delivery. This section collates the references to capacity and workforce issues that occur throughout each of the reports.

The Funding and Planning resources have been pivotal to the DHB tasks, encompassing strategic planning, prioritisation, purchasing and monitoring functions.

The funding and contracting expertise was built up to cope with the devolution of contracts which occurred in two rounds, June 2001 and October 2003. The due process of checking the devolved contracts was demanding for DHBs. For example, one DHB (C IR:30) was described in the interim report as “struggling to manage” and the SSA was engaged to help while the DHB built its own capacity. Those members of the Funding and Planning that were already experienced in the sector were recognised as particularly helpful, and conversely, difficulties were caused by the loss of some key people to the Ministry of Health. In anticipation of the second wave of contract devolution, those contracts concerning the services for the older people with disability, the DHB appointed further staff and designated the SSA to coordinate the audit programme for these services.

This pressure to develop contract management expertise was similar in other case study DHBs. A second case study research team noted in their interim report (A IR:17) that contract management was a “particularly important area for workforce development.” By the end of the research period the DHB (A:51) reported their

funding and contracting section was now fully staffed and well resourced. A third case study DHB (E:44) initially rolled over many of the devolved contracts while it developed the contract negotiation capacity within the DHB, and a fourth DHB (D:74) was described as “*dysfunctional*” by a provider informant due to the lack of capacity to adequately deal with contracting.

The planning processes have also been demanding of DHBs. Although the HNAs were concluded to be a useful exercise, there has been a learning process as DHBs have acquired the necessary skills. Furthermore, not all of the desired information was available to inform these processes. One case study report (B:41) noted that the planning team waited 18 months for some data to analyse different services due to “inadequate hospital information systems.” There was also considered to be a lack of forecasting and projection skills within the DHB. At the end of the research period another DHB (A:51) was reported to have “shortfalls” in their planning expertise, which were managed by the use of external consultants, the rotation of staff and the development of training opportunities.

Consultation and prioritisation processes were also demanding on DHB capacity and capability. In one case study DHB (B:43) a team of six within the larger Funding and planning section worked on interpreting consultation inputs. Some of the case study DHBs described a learning process as they took on the consultation role, and at least some informants questioned whether how well aspects were carried out. Establishing prioritisation processes was also challenging for DHBs. One DHB (C:30) appointed a health economist as a joint position between the DHB and the local university to assist with this task.

Capacity limitations in one section generated constraints in other parts of the organisation. For example, in one case study DHB (C:15) the CPHAC was unable to contest the allocation of money between hospital and non-hospital services because it lacked the information “due largely to the limited resources available to Planning and Funding and the delay in developing a robust prioritisation process.”

Workforce issues were a constraint to strategic decision-making (B: 37) and the capacity of non-DHB providers to take on new services (A:23, E:38). The latter two case study DHBs had the money to purchase new services but the providers were not ready to take on new services or were unable to expand capacity due to staff recruitment problems.

Recruitment and retention issues were heightened for the two smaller and more rural DHBs (A:51-52, D:54, 64). One informant (A:51) considered that small DHBs have difficulty getting top quality staff who are attracted more by the tertiary hospitals, or else smaller hospitals act as the training ground for clinicians as they “*go up the ladder*”. One case study DHB (D:71) with significant difficulties in attracting medical specialists is more dependent on locums but this is costly, due to the higher salaries paid, and it also stops the DHB from claiming ACC surgery revenue. This DHB (D:65) has access to some regional mental health services but this is not particularly satisfactory for the effective management of those clients. For example, services for drug and alcohol addiction clients are provided out of the district.

The servicing of Boards and statutory committees has absorbed significant amount of management resource and time (E:21, B:31, A:20, C:10, 12)). One case study (B:31) reported management informants were frustrated with the time and effort involved in providing information and support to the Board and committees. Senior staff, including the CEO and Hospital General Manager, attended every committee meeting and other senior staff were called into Board and committee meetings as needed. It was estimated that the Director of Funding and planning spent 25-30% of his time dealing with the Board and advisory committees. New management staff were reported to be initially keen to give the Board as much information as possible but that the keenness wore off in response to the perception that the Board did not always follow agreed processes.

Within this DHB (B:22) the boundaries between the Board, statutory committees and management were, at times, contentious. The statutory committees’ expectations were observed to be that they had a secretariat and therefore could ask for papers and information directly from management. The Planning and Funding section was placed under operational pressure from this and the case study noted that there were several

occasions when a committee had asked for advice, assistance or information from the Executive but these requests were not responded to. Management informants who had worked under previous systems perceived the DHB system as more bureaucratic and that the boundaries were not clear. Both Board and management informants (B:31) perceived the Board's relevance to the day to day operations as "minimal". In another case study (E:53-54), Board members sometimes approached senior managers directly for information, or alternatively Board or committee members brought up individual clinical cases within meetings. Protocols were developed to give guidance on appropriate processes.

Two case studies found the reporting requirements to be demanding on management time and energy. One DHB (D:33) noted that, being a small DHB, reporting puts a relatively greater strain on the limited resources and capacity. Another case study report (A:37) noted that the amount of information demanded by the Ministry of Health requires "*this enormous clerical infrastructure in a hospital*". It was also commented (A:39) that the management time and attention absorbed by reporting was time that could be spent on developing and improving future health services.

One case study (B:46) reported tension amongst some staff due to the Ministry's perceived lack of capability: it had been "geared up" to manage one HFA and had inadequate resources to work with 21 DHBs.

The implementation of the Primary Health Care Strategy placed extra demands on DHBs and providers. One case study DHB (C IR:19, C:47) was slow to implement the PHCS because of the insufficient dedicated staff time. They sought additional resources from the Ministry of Health for this but were declined. Another case study (B:58) reported that the DHB's Primary and Community care team experienced a total staff turnover during the period under research. This team of three had expanded to six by 2004.

The establishment of the PHOs placed pressure on the capacity of primary care providers with regard to resources, management and information technology skills (B:56) and also required different configurations of clinical resources. For example, one DHB (A:51) actively worked to support the development of multi-disciplinary

primary health care teams. Another case study DHB (E:33) identified capacity as the key issue with regard to the implementation of the PHCS. Experienced nurses offering leadership, people strong in Māori health, and good project managers were noted as key personnel.

The PHOs also have been demanding in terms of time and work from people in the community, which prompted one informant to comment *“its outrageous really, it is huge, just huge”*. A PHO informant (D:60) was appreciative of the positive relationship with the DHB and the invitations to be present on forums but noted the opportunity costs of this involvement: *“requests to attend hui take us out of our primary role which is service provision”*.

Size was identified as an important dimension by both large and small DHBs. One of the larger case study DHBs (C:48, 52) reported some tension arose because of the “highly variable” size and capability of Boards. Smaller DHBs were seen as lacking the capacity and capability that the NZPHDA model requires. Regional specialist service provision ensures smaller Boards can access clinical services. It noted that larger Boards can be outvoted in regional forums and may not be able to secure value for money in joint activities. An Account Manager, commented favourably on the size of another of the larger DHBs (B:47): *“[the size] has enabled it to drive better synergies and have better economies of scale than a lot of the other DHBs”*. One of the small DHBs (D:102) commented on the diseconomies of size, including the paperwork and reporting requirements which are the same regardless of the size of DHB. Workforce capacity issues were also perceived as more difficult because of the small size of the DHB. Within this DHB two informants (D:99) considered the success of the Reforms would depend ultimately on the Board’s capacity to gather a stable and committed workforce with sufficient expertise around at management and clinical leadership levels.

Collaboration through a Shared Service Agency was noted by one case study report to offer advantages of sharing scarce capacity and capability with concomitant economies of scale (A:50). However another case study (E:45) noted that while the SSA was able to manage some contracts on behalf of the DHB, this system had the disadvantage of blurring accountability lines. A joint venture between two

neighbouring DHBs offered economies of scale in purchasing and support services (E:42).

The DHB system also had capacity implications for non-DHB providers. Contracting with multiple purchasers generated frustration and increased costs, according to one informant (E:44), who stated “*it had doubled the workload*” and that the additional costs of multiple negotiations inevitably must come out of funds previously used for service delivery.

The non-DHB providers were also in competition with the DHB for nursing staff. Recruitment and retention was noted (A:51) to be a particular issue in the aged care sector.

Demands arising from industrial relations were thought to have increased since 2001 health reforms, due to the less commercial approach, the coincidental labour reforms and the multi-employer negotiations with the help of DHBNZ (A:52, B:55). Another case study (C:38) reported that workforce was the largest area of expenditure and the most difficult to control. National industrial agreements and the Holiday Act both have had large impacts.

One case study (B:60) included in the weaknesses of the model that there is too much to do, too many expectations, too many initiatives, and not enough capacity to do it. It was suggested regionalisation may be better. It was pointed out that each DHB now had some functions which had previously been shared nationally. One informant (B:62) stated

*“DHBs have got a careful balancing act ... deciding what size lens to use. They could use one which is so large and national that it loses the local focus; or they could use one which is so localised that it loses all meaning.”*

Another case study informant (A:64) saw a higher degree of collaboration and cooperation as a key to improvement, which was considered to be emerging slowly.

## 5.8 Collaboration With Other DHBs

All the case study DHBs collaborated with other DHBs, including over service configurations, capital planning, mental health planning (through the Regional Mental Health Networks), regional employment agreements, and other regional issues where collaboration is deemed desirable. Collaborations were facilitated and formalised through the national organisation DHBNZ, and through regional groupings via the Shared Service Agencies, the regional DHBNZ discussions and through the Regional Mental Health Networks. In addition, DHB to DHB cooperation was common, particularly for those DHBs with contiguous boundaries. Some of this contact was routine and scheduled, some more informal. One case study (A:50) noted that the informal contact between colleagues in the other DHBs was particularly useful.

The contact between DHBs over service configurations ensured that less common specialist services were made accessible to smaller DHBs. The issue for larger DHBs was the need to maximise their fees for services provided, whereas for the smaller DHBs there was a desire to minimise costs, particularly as they were purchasing from a monopolist supplier. Collectively there has been a need to develop appropriate ways of managing services and formal agreements about access. The inter-district flow system allows for payment for services between DHBs.

Other collaborations included:

- five DHBs jointly owning a laundry service, with some financial savings;
- joint purchasing of consumables and other supplies;
- pooling “back-office” services such as finance and human resources;
- patient information systems in common;
- joint negotiations and agreements on employment matters; and
- collaboration on information management systems and IT.

Contracting through the lead-DHB contract system is another way of collaborating. However this arrangement has tended to be problematic for all participants. One case study DHB (E:46-47) which held some lead DHB contracts considered that they should have the final say on the contract terms, as they carried the risk. However the DHBs covered by the contract insisted that decisions should be made jointly with them as any decisions would impact on their populations. One provider informant noted that they usually preferred to deal directly with the DHB purchasing the service rather than through the lead DHB as intermediary. Some of these contracts have been unbundled.

Pacific managers from the seven DHBs with relatively high Pacific populations met every two months to support each other and to exchange information. In addition Pacific Board members from two neighbouring DHBs developed a supportive working relationship.

Although overall informants favoured DHBs collaborating, some issues were identified:

- One of the larger DHBs observed that their needs are different from those of smaller DHBs with lesser capacity. Although costs are often based on size, their needs may be outvoted in common forums, and therefore may not be able to secure value for money by participating in joint activities.
- Collaborative decisions can reduce the individual DHB's autonomy and decision-making authority.
- DHB to DHB interactions can increase paper-work and the number and length of meetings.
- The pressure to collaborate can place DHBs in the position of being pressured to join when it is not necessarily advantageous for every participant.
- National and regional negotiation of contracts can override the collaborating opportunities issues that apply between DHBs.

## **5.9 Shared Service Agencies (SSAs)**

The four SSAs are jointly owned by the DHBs within that regional grouping. The role of each of the SSAs has developed differently, determined by its specialist capacity and the needs of the owner DHBs.

The Southern SSA, South Island Shared Service Agency Limited was noted as providing a forum for discussion of regional access to services.

The Central region grouping of DHBs is supported by the Central Region Technical Advisory Service (CRTAS) which was perceived to have moved from an establishment phase to one of providing significant analytical support, regional service planning and some auditing work. This agency attracted positive comment from informants who saw advantages in sharing capacity and capability with concomitant economies of scale. CRTAS was also credited with providing good and accurate information; leading the way on preferred service management; and their audit work. Although this agency was approved of overall, one case study also noted that it was not always easy sharing resources with co-owners who may have different work priorities or direction.

The Midland region is served by the Health Share Limited Shared Service agency. It was noted that the DHBs in this region have been progressively downsizing this agency. One case study DHB commented they were trying to retain the work within the DHB as much as possible, to keep employment within the district.

The Northern District Shared Service Agency was initially set up to administer DHB contracts but has expanded its focus to being an independent forum through which the DHBs can work together to develop a regional approach to service planning and to strengthen regional collaboration.

## 6 Service Areas

### 6.1 Devolution of Primary Health Care

#### 6.1.1 Support for the Primary Health Care Strategy

DHBs are responsible for managing the implementation of the PHCS, negotiating contracts and holding PHOs accountable. Two case study DHBs developed their own version of the PHCS to adapt it to local circumstances.

There was broad support for the PHCS's goals and objectives. For example, one case study report (E:33) observed that the Board, management and providers were all aligned in their support for the PHCS. This alignment strengthened as implementation proceeded, despite difficulties. One informant stated *"I think there's broad agreement that the policy is a good policy, but it's implementation is very, very difficult"*. For this DHB, recruitment to build capacity was singled out as being the biggest barrier.

An informant in another case study (D:56-57) stated

*"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 in this case study were hopeful that the PHCS would eventually deliver better health outcomes, thus reducing the demand for secondary services; removing access barriers to primary care; promoting innovative practice, and encouraging cooperation and collaboration between providers. The PHOs were seen as a vehicle for different organisations working together with their various contributions, and for cooperation between clinical teams. There was also strong approval for the focus on early intervention and preventative work, which one person hoped would generate a momentum towards people self-managing their health.

Within this DHB, one Māori informant likened the PHO to being like a whānau, incorporating various viewpoints, sharing ideas about how to achieve the common goal of population well-being, and that doing this collectively would achieve more than doing it alone.

The establishment of PHOs was a key plank in the Government's population health strategy. However one case study DHB (C:47) complained that the pressure to "*follow the money*" resulted in a lack of strategic thinking about primary health care and a concentration on PHO implementation. Furthermore this required a significant investment of resources which then precluded focus on other issues of importance and the development of a strategic framework.

Another case study informant (B:59) saw the PHOs as one of the "*big success stories of the sector*", but highlighted the risk that too much would be expected of primary care. "*With a deficit and the hospital still dominating the scene, the primary care strategy becomes the sort of cure-all, that is the problem.*"

### **6.1.2 The Process of Implementation**

There were some themes of tension evident in the case study discussions: the expectation that the Ministry should have provided more leadership through this implementation phase; frustration at the slow devolution of decision-making to the DHBs; and the need for the DHB to establish working relationships with the primary care providers.

#### **Case study A**

This DHB (A:44-47) took an initial step of developing its own adaptation of the PHCS, with the help of a primary health care reference group comprised of stakeholder representatives. The reference group has functioned more as a technical advisory group, rather than a consultation group, and has guided the PHO establishment phase and helped develop the Strategy for the DHB. The Strategy boosted the resources directed into primary care, with a particular emphasis on building primary health care teams. Some funds were invested in workforce and

workplace development, to supplement the funds made available to PHOs from central Government funding for capitation and services to improve access. For example, the additional funds from the DHB could be used to establish a health promotion clinical team.

Other actions taken by this DHB were to appoint a Project Manager in the Funding team to liaise with and support PHOs. The DHB was also working towards establishing a management services organisation within the district, to provide collective administrative support to the PHOs.

The DHB's approach to PHO establishment was described as '*cautious*'. An informant commented that, by moving more slowly than other DHBs, the DHB has been able to learn from what others have done. Initially the DHB requested providers to indicate interest in forming PHOs, but found that to be not a successful strategy. The DHB then took an approach of raising public awareness about PHOs and letting the community interest drive developments forward. Three of the PHOs which developed arose from the community being mobilised by the threat of changes in the health services of that local area. This left a more diverse, larger city community still to be enrolled at the time of the second round of interviews. The DHB had by now stepped into a facilitative, leadership role in an effort to encourage the two associated groups of doctors to work together in one PHO. That issue remained undecided at the end of the research period.

During this extended PHO establishment phase the DHB has had a policy of encouraging mergers, preferring to work with as few PHOs as possible. Other selection criteria were to select the best developed proposal for a geographical area to avoid multiple PHOs in one area, and to apply criteria developed by the local manawhenua partnership group.

This DHB (A:47) commented that the Ministry was readily available for advice and support which was appreciated but was found to sometimes not reflect the practicalities of the situation. One informant expressed disappointment that the Ministry would not share the solutions used by other DHBs and PHOs.

### **Case study B**

This case study DHB (B:56-59) proceeded in September 2002 with PHO establishment by requesting registrations of interest. This resulted in seventeen applications which included both those groups seeking to become PHOs and those signalling an interest in being involved. Seven were short listed and were considered by an evaluation panel against pre-agreed criteria. The Māori Partnership Board was also consulted. According to informants, the Board's final selection was not in accord with the advice given by these two evaluating committees. Starting from April 2003, six PHOs were established and by late 2004 95% of the district's population was enrolled. The identified groups not covered at that time included patients of GPs nearing retirement, student health, a youth health organisation, and a "Pacific-led" group which delayed setting up. The Board was also concerned about coverage for refugees, who were also a high-needs group.

This DHB had adopted the priorities promoted by the Government to address health inequalities by targeting Māori, Pacific and low income populations. However, in practice, the providers serving these populations struggled to find the capacity, resources or management and information technology skills to undertake the PHO establishment phase. In the process they were placed under severe pressure.

The DHB established a small Primary Care Team within the larger Funding and Planning division to work with PHOs, to facilitate establishment and to address the numerous issues raised, with "numerous formal and informal forums and channels of communication" occurring. In addition the DHB supported the establishment of a Primary Care Organisation Advisory Group which met every two months and included two representatives from each of the PHOs and senior DHB staff. This is an information-sharing rather than a decision-making group.

There was some confusion evident in the boundaries between the Primary Care Team and CPHAC. The Team sent monthly updates to the Committee, and also a six-monthly report on primary care and PHOs was prepared for the Board. Difficulties arose when the Team tried to operationalise Board decisions and it became evident that not all CPHAC members agreed with the direction, prompting the Board to revisit decisions.

No particular tension between the DHB and Ministry was reported in this case study report as it was noted that, although the Ministry made the decisions, the DHB was consulted.

### **Case study C**

This case study DHB (C:46-47) found the lack of devolution of decision-making very unsatisfactory. Despite being nominally responsible for the establishment of the PHOs and holding them accountable, the Ministry of Health retained control over the final approval to establish PHOs, and on occasions over-ruled the DHB's advice. This DHB reported that there was a lack of transparency about criteria with some proposals rejected by the Ministry even though they appeared within guidelines, leaving DHB informants to conclude there were '*rules*' which were '*hidden*'. The DHB was also aggrieved that local primary health providers went directly to the Ministry when they were unhappy about a decision made by the DHB. The providers recognised that power still lay with the Ministry rather than the DHB, and the Ministry did nothing to dissuade them from this view, according to DHB informants.

Other sources of frustration for this DHB were the lack of resources made available by the Ministry to support implementation; perceived inflexibility in the national PHO work plan; the lack of recognition of local situations and workloads; and the promotion of PHOs to the wider community was regarded as "*too little, too late*". The Ministry of Health advertising campaign was regarded as "*poor and misleading*".

### **Case study D**

In this DHB (D:57-58) district, one PHO was established at an early stage of the implementation of the PHCS. Other primary care health providers perceived the PHO to be receiving advantageous funding which stimulated the remaining general practitioners (GPs) to band together to form a second PHO, despite being relatively disparate groups prior to this time. The DHB managers held monthly liaison meetings which brought together the representatives from both PHOs to discuss issues, debate changes and to promote the interchange between GPs and the hospital. At the time of the interim research report, there was considerable tension between the two PHOs, over a number of issues including resources, territory, asserting tino rangitiratanga,

enrolments, rosters for out-of-hours work, and other implications. Between the first and second rounds of interviews the competitive tension between the PHOs had lessened and there was a general consensus that it was in the best interests of all involved, including service users, to work cooperatively. By then some of the “teething problems” had been resolved and some informants were “starting to feel they were gaining some traction in primary health care” around early intervention and primary prevention.

### **Case study E**

This DHB (E:33-36) took a highly proactive approach to the implementation of the PHCS. The DHB transparently stated its preference for two to four PHOs based on geographic sub-districts, to ensure the maximum coverage of the district’s population and to achieve non-competitive enrolment. In practice this approach was supported by two of the three IPAs concerned, but not the third. This latter IPA challenged the geographic-base theory of PHOs, pointing out that service users do not necessarily choose a PHO close to their place of residence, for a variety of reasons. The DHB has had to compromise and accept that, without the cooperation of primary care providers and stakeholders, its preferences are not achievable. By the end of the research period, “the PHO environment has become increasingly differentiated along ethnic lines” but some research informants expressed concerns about the viability of small PHOs serving specific populations.

### **6.1.3 Stakeholder Perspectives**

The establishment of PHOs has meant that providers previously working in competition were now being pushed into cooperating with one another. It has also meant the re-structuring of private companies into PHOs acting in formal relationship with DHBs and with community governance boards.

Three of the case study reports quoted provider informants as stating the DHB has been supportive and helpful in the PHO establishment phase and subsequent operation. For example, one informant (A:45) described the DHB as taking a consultative, friendly and cooperative approach. One Pacific informant (B:56) acknowledged with appreciation the free advice, support and expertise in information

technology given by the DHB, whereas the DHB informants expressed concern that the desire to help those people most experiencing health inequalities had led inadvertently to excessive pressure being placed on small providers least endowed with administrative and information technology capacity.

Not-for-profit community providers (B:57) welcomed PHOs because of their scope for developing integrated care approaches; because of the emphasis on social rather than medical models of health; and because PHOs were seen as a ‘bottom-up’ structure. A non-DHB informant observed that the DHB seemed keen to ensure community voices were heard in the PHOs. On the negative side, some NGO providers found it problematic to work with a number of PHOs (sometimes across DHB boundaries) and some perceived risks to small primary care providers of losing their special character in joining with larger PHOs.

Two case study reports indicated some tension in the provider-DHB relationships. One case study DHB (C:47) complained about the provider organisations relating directly to the Ministry of Health when they did not like a decision of the DHB, and that the Ministry did nothing to dissuade this, undermining the PHO-DHB accountability relationship.

Another case study report (D:61) noted a PHO informant expressed disagreement with the DHB having the power to veto a proposal which the PHO put forward. In the opinion of this informant the DHB lacked sufficient understanding of the primary care sector to make such decisions. Provider informants expressed the views that most of the health outcomes were not measurable; a lot of what they did as primary care providers did not feature in the information the DHB required of them; and that the DHB should not be “*too involved in how the PHO met its contractual obligations*”. In this informant’s view, as long as they met the contractual specifications then they were being accountable. Furthermore, it was difficult to meet the expectations of the DHB as well as those of their community. Another provider informant expressed reservations over the time spent on meetings which reduced the time available for health care provision.

Three case studies noted the bargaining power held by IPAs in the district. As already noted, one case study DHB (C:47) was frustrated by the IPA going directly to the Ministry of Health. A second case study (B:58) noted the involvement of a large IPA, which provided management support to a number of PHOs and were able to access DHB and Ministry decision makers in a way that smaller community-based primary care organisations did not. A third case study (E:34) observed how the DHB's preferred approach was dependent on the agreement of the IPAs in the district. In practice, two of the three IPAs agreed whereas the third held a different point of view (regarding the geographic base for establishing PHOs). The DHB has pragmatically accepted the compromise, given that it is dependent on the cooperation of primary care providers.

#### **6.1.4 Issues Raised**

Both provider and DHB informants raised the issue of the risks to small providers in joining a PHO. One DHB (B:58) informant suggested a small provider joining a larger mainstream PHO *“should be very clear about their agenda at the beginning and get some agreement about ... not only their own security but their own growth and capacity and the fact that they might want to exit”*. This DHB held monthly meetings between DHB management and Pacific providers. Informants from both sides described the relationship as *“transparent, reciprocal and trusting.”* There was also a fono with Pacific providers to discuss issues raised by the development of PHOs. For Pacific providers the model of health care is a holistic one which often involves support to the whole family. However this is not easily recognised in the funding model which is just based on population.

PHO responsiveness to Māori varied, with some PHOs showing awareness of the need to be more responsive and to engage in consultation. The Māori partners in two case study DHBs (A:46; B:57) developed Māori-focused policies which acted as a guide to PHOs to ensure the PHOs are responsive to Māori. One informant expressed hope that as relationships deepened between PHOs and Māori providers, and with the HNA highlighting issues, there would be better understanding of how to improve Māori health.

### 6.1.5 Current Status and Future Developments

In one case study (case study A:45), it was noted that the PHCS had heralded in changes:

- new investment tends to be directed at the PHOs rather than secondary services;
- primary and secondary services are increasingly working together; and
- providers who previously had worked competitively are increasingly working in cooperation.

In this DHB one informant outlined a vision for cluster services developing around a group of PHOs as an effective service development in the longer term. While the PHOs were seen as being the main vehicles for implementing the PHCS, it was anticipated that the DHB would withdraw as a provider, particularly with regard to psycho-geriatric, continuing care and primary maternity services. Within this case study, there was general optimism that the PHCS would achieve the Government's vision for improved population health in the longer term, though the inter-sectoral work which was seen as crucial to addressing the determinants of health was "*hard to get on to*" and "*so often intangible*". Little inter-sectoral work had happened by the end of the research period.

The underlying economic and social determinants of health were also picked up as an issue in a second case study DHB (D: 60). One informant pointed out that "*most of the health outcomes are not possible to measure so what tends to get measured are not necessarily the important things but the measurable things*". In the view of this informant the measurable things were only a small part of the content of primary care. Within this case study the relative roles of the DHB as the secondary care provider and the PHOs as the agents of primary care delivery were still being negotiated. There was some resentment expressed at the power of the DHB to veto SIA proposals developed by the PHOs; criticism from another informant that the DHB was too involved in wanting to know how the PHO was going to achieve its aims; a Board member commented the DHB was 'too prominent in the overall provision of health';

and a number of comments reflecting the view that the DHB did not understand adequately the primary care sector and therefore should not be in a role that allowed it to prescribe what should be done or to veto initiatives taken.

Despite these reservations there were positive views about the aims and objectives of the PHCS. This case study (D:63) outlined their challenges to implementation were seen as the lack of role models to follow; mistrust and suspicion that further reforms may occur; problems arising from the differing funding formula; overcoming internal dynamics as some saw the PHO as a type of cash cow; and the fact that it would take long term agreement and cooperation to achieve health gains from prevention programmes. Within this case study there was also some disquiet expressed about the place of the community, with one informant complaining that the DHB did not engage with the community with regard to the PHOs, only the PHO management, and another informant expressing the view that the PHO management did not engage sufficiently with the community.

A third case study (E:36) was concerned about the viability of its small PHOs based on ethnicity. A fourth case study (C:47) noted that, despite the PHOs having now been established, the DHB “has yet to provide a policy context for primary health care.”

The fifth case study (B:59) summed up the outstanding issues at the end of the research period as:

- *‘the ability of PHOs to function in terms of governance and community involvement’*
- the slow progress being made on low-cost accessible care
- The pressure on the primary care sector: *“with a deficit and the hospital still dominating the scene, the primary care strategy becomes the sort of cure-all”*.

However one informant from this DHB described the primary health care strategy and PHOs as one of the *“big success stories of the sector”*.

## 6.2 Public Health

The Ministry of Health continued to retain responsibility for funding public health services throughout the research period. The Ministry contracts with lead DHBs in each region and NGOs to provide health promotion and health protection services. Of the four case study reports that commented on this issue there were mixed views whether the devolution of the public health funds to DHBs should occur.

Most informants were impatient for this devolution to occur, particularly as the 2001 health reforms placed so much emphasis on population health. One informant (D:81) represented this viewpoint: *“Here we are in DHBs improving the health of our population but the one area most fundamental to that is still held centrally”*. One informant from the same case study stated that delivery of public health from a Wellington perspective is *“not actually of much benefit or accountability”*. Furthermore, the public health service was working to service specifications predating the New Zealand Health Strategy and public health workers *“were also required to be mindful of 23 or more policy documents issued with public health content”*.

Another reason for devolution (E:38) was perceived to be “for consistency of allocation of responsibilities across the health sector.” Board members and senior management wanted the devolution to occur as this DHB is not a lead DHB for public health contracts. Therefore it can only try to influence purchasing decisions by input into regional discussions to seek the allocation of resources to activities consistent with its agreed priority issues. The DHB’s influence over national level public health decision-making was perceived as “minimal”. Personnel from this DHB (E:44) were impatient for devolution to occur, because they saw the devolution of public health funds as improving local planning and decision-making; aligning with the refocus towards prevention; and allowing the integration of some public health services with primary health care.

Key informants from another case study (C:52) reported that that they would like to see public health funds devolved and ‘the sooner the better’. It was acknowledged that there were essential national public health roles, but that overall there should be some urgency to complete the devolution process.

A few informants across all of the case studies were more accepting of the status quo, with the reasons given that it was preferable for the DHBs to consolidate their roles before taking on this added responsibility; the need for national consistency across programmes 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.

Many informants regarded the devolution of public health funds as inevitable. For example, in one case study DHB (D:87-89) the public health contracts are held with the Ministry but facilitated locally by a Public Health Manager. One of the district’s PHOs has already held both public health and personal health contracts. The public health accountability data is reported to the Board as well as the Ministry of Health, along with the personal health data, but does not cover all the public health issues. Informants in this case study expressed a preference for allocating resources locally as the DHB’s own ideas of public health priorities are different from those of the Ministry of Health. It was speculated that the Ministry desire to retain control is the legacy arising from the Area Health Board era when funds intended for public health were spent elsewhere.

One case study (D:88) noted that a DHBNZ working group proposed DHBs and the Ministry of Health should have shared responsibility for public health funding and planning. This DHB considered they could quickly take on this role as there is already a strong public health focus in both the DHB and in the PHOs, and there were perceived to be appropriate accountability measures. However this shared decision-making was yet to happen.

### 6.3 Mental Health Sector

Although this was not a primary focus of the case study research, the case study reports highlighted some issues for the mental health sector.

In one case study (C IR:25), it was noted that there had been good progress towards meeting Blueprint standards prior to the establishment of DHBs, and systems were seen to be well functioning, including workforce development, clinical-management relations and community services. The devolution of mental health contracts was noted to have proceeded smoothly. Three issues were regarded relevant to strategic decision-making:

- The need to acknowledge the regional scope of services in local decision-making. The RMHN was expected to assist with communication and coordination but was not a decision-making body.
- A review was intended to ensure as much work as possible was done in a community setting.
- The contracting framework for mental health is based on inputs, and some of the mental health funds are ring fenced. The case study report noted the DHB intended to explore the implications of these aspects and consider any possible alternatives.

In a second case study (A:48-49) the vision for the mental health services was defined as integrated, outcomes based, consumer responsive and recovery focused. The RMHN was seen as offering a means of collaboration around planning; a grouping for developing regional services; a forum to debate issues relevant to all DHBs in the region; a platform to develop joint ventures or strategic alliances; and a means of reducing duplication. However some reservations were expressed:

- that the RMHN is too cumbersome;
- DHBs are accountable for the local delivery of services but not regional ones;
- that not all participant DHBs have the same needs; and

- having ring fenced funding is too restrictive, given that recruitment and lack of infrastructure can be barriers to spending the money.

Another issue noted in this case study was the variation in accountability systems used in different DHBs and for different providers. Within this DHB mental health providers were monitored by contractual agreements, accreditation, mental health standards, audits conducted by the SSA, and quarterly meetings between the DHB and provider. Interview informants were positive about the Local Advisory Group and the Māori Mental Health Local Advisory Group, both of which meet monthly to share ideas and to contribute to decision-making processes for mental health services.

A third case study (D:65) highlighted that being part of a regional grouping for access to specialist services was not a satisfactory solution for the DHB. Drug and alcohol services were particularly lacking. Having service users treated away from the district but then returned to the same social situation was seen as very ineffective. In addition to the lack of services, there were also workforce shortages.

Within this case study informants expressed a preference for contracting locally, because *“people have more say in it, therefore ‘will own it better’ and will take more responsibility”*. The Local Advisory Group makes direct input into management about purchasing priorities. This mental health liaison group consists of consumer and family, Māori, Pacific and NGO provider representatives. The RMHN advisory group also has input into all of the local DHB documents concerning mental health, such as the primary care discussion papers, the DSP and the funding programme for the DAP. The quarterly DHB report documents the spending of the ring-fenced mental health service development funds, as is required of all DHBs. One informant commented that although these funds are ring-fenced, in practice indirect costs or overheads can be used to enable the funds to be directed to other purposes.

A fourth case study DHB (E:37-38) is the lead DHB for mental health services in that region. The main concerns raised by this case study were:

- the complexity of local and regional consultation, planning and decision-making;
- uncertainty whether regional service decisions are made autonomously from individual DHBs;
- an ongoing lack of capacity in terms of both workforce and facilities to deliver the necessary acute and other services;
- staff safety, which has been a significant industrial relations issue; and
- non-DHB providers who have had capacity constraints reducing their ability to meet the demand for services.

## **6.4 Rural Sector**

Rural health was seen as a key area for development in one case study DHB (C IR:25) because of the inequalities of access to primary care and other services. The DHB saw the Government's initiatives to support rural workforce and retention as an important opportunity. The DHB supported community stakeholders in forming a rural PHO, facilitating groups to find common ground so that the PHO established would be viable in size. The DHB accepted that the diversity of issues between the rural communities would preclude the option of only forming one PHO.

A second case study (D:64) noted the implications of a dispersed rural community: diseconomies of scale; relatively higher costs; different types of services required; the extra challenges of maintaining a quality service in remote areas; and heightened recruitment and retention problems. There are also implications for the attendance of appointments for rural people.

The population based funding formula has adjustors for rurality but at least one informant questioned whether this was sufficient. One informant commented the difference between rural and urban services was greater than that between Māori and Pākeha services.

## **6.5 Secondary Services**

One case study (E:36) identified “the substantial discrepancy between contracted volumes for services and actual demand” as a pressing issue. This meant higher bed occupancy than was regarded to be ideal. The implications of this were perceived to be risks to patient safety and that it made the reduction of deficit more difficult. An expansion of the secondary care facilities was constructed during the research period to be opened in 2005.

The same DHB identified “reducing the occurrence and impact of adverse provider-arm events by improving the monitoring and reporting of such events” as one of its objectives in the DSP. Although many in the health sector welcomed this proactive approach, some clinicians expressed misgivings.

## 7 The DHB Model

### 7.1 Comparison with Previous Models of Health Care Delivery

#### 7.1.1 DHB Model

The DHB model was compared favourably with previous models across all the five case studies. The DHB model, in comparison with other models, was found by most case studies to:

- have a strong focus on promoting health;
- be more open due to the legislative mandate for community consultation;
- be more transparent;
- have a more inclusive management style;
- have greater integration between hospital and the community, and between services generally;
- raise expectations of increased development of community services;
- increase flexibility and scope for innovation;
- promote collaboration rather than competition;
- have strong national guidelines to counter any tendency towards fragmentation and to promote national consistency; and
- allow local purchasing, approved of because “*local areas know local needs*”.

It was also noted by case studies that:

- Boards are a way of keeping problems “*at arm’s length from central government*”.
- DHBs have to find the balance between local responsiveness and national consistency of service, as summed up by this quote: “*DHBs have got a careful balancing act ... deciding what size lens to use. They could use one which is so large and national that it loses the local focus; or they could use one which is so localised that it loses all meaning.*”

- The auditing under the DHB model was widely found to be onerous but was also recognised as one of the ways by which national standards are maintained.
- Local monitoring of providers was more likely to be effective in detecting risks and facilitating the risk-management.
- There was cautious optimism that the DHB would achieve the Government's vision of improved health outcomes in the longer term.

Less widespread views included the following comments:

- The DHB model was approved of because it moved away from a “*blame culture*” which had existed under previous systems.
- The DHB model was deemed risky because of the instability created by the electoral cycle.
- One case study reported Pacific provider informants as appreciative of the DHB model because they had more presence within governance, management and advisory committees. Because of this presence and the mandatory consultation and responsiveness to local need, it was considered the DHB was more aware of Pacific needs.
- The DHB was seen as improving the participation in communities by people with disabilities.
- One case study noted that although the majority of research informants were supportive of the DHB model, a number of Māori and Pacific respondents preferred the HFA model. Māori informants preferred the single purchaser because there was only a single point of contact, a clearer focus and commitment to the Treaty, and there had been a critical mass of expertise in the field of Māori health. They were also concerned that the PHOs rather than the Māori providers who would now negotiate contracts with the funder. Some Pacific providers found the DHB model overly complex. However other Pacific providers within this case study preferred having a local funder because it allowed purchasing to be tailored to local needs.

### **7.1.2 Comments on the HFA Model**

Some informants favoured the HFA model and would have preferred it to have been given a chance to evolve further. Those advocating this model commended:

- the promotion of national consistency;
- the efforts to develop Māori providers and organisations;
- the joint approach adopted towards contract negotiation;
- the expertise that had been employed by the HFA;
- the efficiency and lower bureaucratic costs; and
- the purchasing decisions being removed from local politics.

One case study attributed the HFA with taking seriously the view that Māori providers have a contribution to make to health care provision. The HFA was reported to have worked with iwi in that district, lengthened the terms of contracts, supported provider development and Māori workforce development, made transitional funds available, and worked towards setting up a joint purchasing board.

### **7.1.3 Comments on the RHA Model**

Only a few informants were positive about the RHA model, and overall there were far more criticisms than compliments about this system. One case study noted

*“It was seen as overly competitive with both purchasers and providers detached from the community. The highly commercial management style was seen as providing financial discipline within hospitals, but some of the implications of that, including the alienation of professionals, were seen as negative. The lack of focus on health and health issues was seen as a serious deficiency, as was the lack of national leadership.”*

Some Māori provider informants commented favourably on the RHA system because of the regional focus, it was perceived as responsive to Māori, the positive relationships with providers, and quick decision-making. Regional purchasing was seen as more objective in the awarding of contracts, as compared to the DHB system.

#### **7.1.4 Comments on the CHE and AHB Models**

The AHBs were attributed with increasing community involvement and the integration of services. However they were also criticised as being too oriented to hospitals and as too parochial. The DHB model was seen as retrieving the positive aspects of this model but with better management systems and even greater community focus.

The legacy of the CHEs was seen as an anti-professional attitude which significantly eroded relationships between management and clinical staff, resulting in a breakdown in trust and fragmentation. One informant labelled this as '*disastrous*.' Some also attributed these systems with the legacy of a competitive culture which the DHB has gradually turned around.

The advent of managerialism was seen as both positive and negative. It was seen as helpful to challenge behaviour and systems which were not so much about care as preserving status quo, but introduced the negative that it gave power to those who knew little about the sector. Another informant commented that the managerial emphasis on counting episodes of care behaviour missed the point of what makes up care, and that there needs to be an environment which is supportive of clinical care arising out of partnership between clinicians and managers.

### 7.1.5 Comparison Between RHA, HFA and DHB Models

One case study summarised the views of informants by the following table.

	<b>RHA</b>	<b>HFA</b>	<b>DHB</b>
<b>Health focus</b>	Not present	Emerging	Strongly present
<b>Community involvement</b>	Not present	Emerging	Strongly present
<b>Integration of funding</b>	Present	Present	Present
<b>Locus of integration</b>	Regional	National	District
<b>Integration of local services</b>	Not present	Emerging	Emerging strongly
<b>Competition/collaboration</b>	Competitive	Less competitive	Collaborative
<b>Governance style</b>	Corporate	Corporate	Democratic/corporate
<b>Investment in structure and governance</b>	Moderate investment in governance	Little investment in governance	High level of investment in governance
<b>Management style</b>	Commercial	Managerialist	Managerialist/professional
<b>National consistency</b>	None	Emerging through funding policy	Present through national strategies

## 7.2 Strengths of the DHB Reforms

### **Goals of the Reforms**

There was widespread approval through all of the case studies on the key goals of the reforms: the integration of health services, 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.

### **Striving for Health**

Some Māori informants commended the holistic approach as akin to their own concept of health, encompassing mind, body, spirit and whānau/ family. One informant stated “*What’s good for Māori is good for everyone.*”

### ***Acknowledgement of the Treaty***

The reference to the Treaty in the NZPHD Act was seen as a strength by some informants because it made explicit the requirement to work with Māori in partnership.

### ***Governance Structure***

The inclusion of elected Board members, the consultation with the community, the Statutory committees with external representatives, management working with clinicians, and the increased participation of Māori and Pacific representatives were all seen as enhancing the governance structures.

### ***Community Involvement in Strategic Decision-Making***

The involvement of the community was seen as increasing understanding of the issues and enhancing ownership of the selected solutions. Furthermore, the engagement of the community in the endeavours has the potential to promote health.

### ***The More Transparent Culture***

The openness of the DHB system was seen as a major strength and a significant component of the engagement of the community in the striving towards health. The presence of the media and the openness of decision-making was perceived as reducing suspiciousness about the reasons for decisions and also as increasing public understanding of the issues.

### ***Integrated District Wide Approach for Maximum Gains***

Informants saw the potential to plan the health needs of a district in an integrated way as a major strength. This was perceived as allowing the DHB to make decisions based on the assessed needs locally, to consider innovative practice, and to determine priorities locally to maximise health gain and the prevention of ill health.

### ***Accountability***

The transparency of decision-making and local monitoring was seen as creating a directness of accountability systems to the community.

### ***Co-operation Versus Competition***

The emphasis on cooperation, collaboration and working in partnership was seen as strengthening relationships locally, regionally and nationally. There was a perceived shift away from “*shame and blame*” cultures to one of promoting mutual problem solving and an approach of “*how can we learn from it?*”

### ***Innovation***

The devolution of decision-making and purchasing to the local level was seen as promoting flexibility, responsiveness to the local health needs and as promoting innovation.

### ***The National Health Strategies***

The health strategies provide leadership and clear goals for quality improvement.

### ***The Primary Health Care Strategy***

This strategy was viewed positively and was described as “*visionary*” and as providing “*incredible leadership*”.

## **7.3 Weaknesses of the DHB Reforms**

### ***Numbers of DHBs***

Many informants across all case studies considered there to be too many DHBs, creating an overly costly administrative structure. Informants from the large DHBs considered that small DHBs lacked the capacity and capability and that it was “*frustrating*” for larger DHBs to prop them up. Having 21 DHBs was considered unsustainable in the longer term. Some informants highlighted the potential gains in efficiency if DHBs were amalgamated. Smaller DHBs were seen to suffer from diseconomies of scale as they still have to fulfil the same administrative demands and reporting requirements as larger DHBs.

### ***Central Versus Local Decision-Making***

Four case studies reported tension over the degree to which decision-making was devolved. Some informants considered there to be excessive central Government control which was sometimes politically determined. Preference was expressed for greater devolution to the districts. The political constraints limited the degree to which the DHB was able to be responsive to the preferences and priorities of the local community. One case study commented the model is a way of shifting blame away from the centre rather than shifting decision-making.

One case study stated there was a discrepancy between how the model should work in theory and how it was actually working. This view was consistent between the first and second round of interviews. The lack of devolution of decision-making was perceived to create much duplication and therefore “major inefficiencies.”

### ***Having Elected Board Members***

Four case studies noted the stability of the Board was at risk because of the three year electoral cycle. It was observed that it takes Board members a long time to “get up to speed” and then there is the threat of the loss of institutional memory with the non-election of those members. Dissatisfaction was also expressed about the process of appointments to replace Board members in the event of resignation mid-term.

The accountability of Board members to the Minister is not well understood by electoral constituents and therefore the public’s expectations of what members should achieve are often unrealistic.

Lesser concerns were the Board members’ conflicts of interests and hobby horses that are not well managed. One informant commented the Board members may be well intentioned but still lack the requisite skills.

### ***Reporting Requirements***

Most of the case studies found the reporting requirements of the Ministry to be excessive, with one describing them as “*sometimes futile*” Another case study referred to “*inappropriate micro-management by the Ministry of Health*”.

### ***Inadequate Funding***

Four case studies complained the resourcing was inadequate for the tasks required.

### ***Too Many Strategies and Initiatives***

The large number of national health strategies was perceived to be overwhelming, resulting in DHBs selecting priority areas to focus on. The existence of a health strategy raises community expectations which a particular DHB may not be able to fill.

### ***Information Management***

Some informants reported the data needed for decision-making was not available.

### ***Loss of Contestability***

The close relationship between the funding division and the provider was widely feared to threaten the contestability of purchasing decisions, according to non-DHB provider informants.

### ***Clumsy Bureaucratic Structure***

In comparison with the HFA, the DHB structure was perceived to be more complex, and therefore more bureaucratic. Informants from the smallest DHB were concerned about the diseconomies of size with regard to the paperwork and reporting requirements which are the same regardless of the size of DHB.

### ***Escalation of Costs***

The price of greater transparency and accountability is increased costs of information gathering, IT systems, more managers and more attention to obtaining informed consent, thus reducing efficiency and therefore reducing services to patients.

### ***Pākeha Domination***

One informant stated the greatest barrier to progress with Māori health outcomes was that the DHB model is still 'a Pākeha model' driven by middle class white people.

### ***Issues With the PHCS***

The implementation issues with the PHCS were widely commented on and some providers found the work and time commitments onerous. In addition the emphasis on cooperation and collaboration between providers was approved of but also found difficult in some situations after years of competition.

### ***The reforms Do Not Address Inter-Sectoral Issues***

Some informants commented that health was determined by a number of factors not under the control of the health sector, such as income, housing, the Government's tax policy, the local authority's environmental management, and the role of the local runanga and hapū.

### ***Workforce Constraints***

The success of the reforms would ultimately be determined by having key personnel available. Recruitment and retention continues to be a major constraint in many DHBs. Three case studies referred to the fragmentation of the critical mass of skills that had been present under the HFA model.

### ***Multiple Levels of Decision-Making for Some Services***

One case study highlighted this issue, citing the mental health service as an example where there are Local Advisory Groups, regional networks, and other forums, plus various consumer representative groups.

## **7.4 Potential Improvements to the Model**

Three case studies included changes that informants would like to see introduced. Please note that some of these were reported by a single case study and within that, possibly a single informant. These suggestions included:

### **7.4.1 *With Regard to the Reforms Overall***

- Some informants emphasised the need for the reforms to bed down, and to not introduce further change.
- Reducing the numbers of DHBs was seen as a way of potentially reducing costs and freeing up funds for service delivery. Further collaboration would allow the sharing of support functions across DHBs.
- Reducing the number of strategies to a few key ones and measurable milestones.

### **7.4.2 *With Regard to Board Members***

- More appointments to Boards (one informant was of the opinion all members should be appointed) to ensure the right mix of skills and knowledge of the sector.
- More governance training and more scope for Board members to learn about key issues in the sector.

### **7.4.3 *With Regard to Consultation***

- The DHB should set up advisory committees so consumers and organisations can have their voices heard in a more regular, consistent, formal fashion.

#### **7.4.4 With Regard to Management**

- Improve management competency with appropriate and adequate management training.
- Management should “*have more leverage*” with the provider arm.

#### **7.4.5 With Regard to Funding**

- Regionalise the funding functions throughout the country.
- A single purchase with national contracts.
- Rapid move towards full population-based funding based upon accurate population data.
- More openness and clarity about funding decisions, especially the allocation of funds between DHB and non-Government providers.
- Better alignment between the volumes of services provided and what is funded.

#### **7.4.6 With Regard to Providers**

- More consultation with providers.
- Once the money is allocated to providers, the DHB should give over control over the way the money is spent so that providers, not the DHB, are responsible for the use of funds.
- Improving the support to providers to allow greater certainty to facilitate longer term planning.
- Change the attitude of the DHB towards providers to one of partnership and constructive engagement.

#### **7.4.7 With Regard to the Role of the Ministry**

- Clarification of the role of the Ministry, more autonomy to the DHBs, and a preference for the Ministry to only focus on strategic policy were related and recurrent themes across all of the case studies.
- DHBs should report to the Ministry of Health on outcomes.
- The Statutory Committees are too prescribed and DHBs should be able to define them to make them useful to the DHB.
- One informant suggested if the Government is serious about improving Māori health then the documents around health delivery should be in Māori as well as in English.

#### **7.4.8 With Regard to Collaboration**

- For DHBNZ to take on a greater role on some of the DHB's operational functions as a means of reducing costs and overcoming capacity constraints in DHBs.

#### **7.4.9 With Regard to Integration**

- More integration of strategic planning between DHBs and local Government.
- 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.
- Greater integration between provider services in the community.

#### **7.4.10 With Regard to Primary Care**

- Match the annual planning cycles of PHOs and DHBs.
- Make more use of the primary care infrastructure that is starting to emerge through PHOs.

#### **7.4.11 With regard to public health**

- There were mixed views about the devolution of public health funds but those advocating the devolution of public health funds to the DHBs perceived that development would enable DHBs to be totally responsible for the health needs of their community within the funding envelope.
- Hold a public health care forum every six months in the major areas to stimulate public debate and local interest in key issues.

#### **7.4.12 With regard to other sectors**

- Fund and manage tertiary services completely separately, outside of the DHB model.
- Hold round table discussions for all involved in mental health.

## 8 Implications

### 8.1 With Regard to the DHB Model

In evaluating the DHB model, there are various criteria that can be applied: equity; efficiency; engagement of the community; integration of services; responsiveness to Māori, Pacific peoples and other minority groups; and the achievement of larger population health goals. The various viewpoints expressed throughout the case studies and in this overview report reflect and depend on which criteria are being used as the lens to view through.

There are also some natural dimensions of dynamic tension which have been highlighted: between equity of access and national consistency compared with local responsiveness; between local decision-making and central Government leadership; between local decision-making and achieving economies of scale by more efficient pooling of resources and services; between accountability through reporting requirements versus more flexible and innovative systems based more on trust; and between promoting what is best for their district compared with regional “responsibilities” to ensure all DHBs have accessible and sustainable services.

Throughout the case studies there has been strong endorsement of the value of local decision-making, particularly with regard to assessing the needs of the resident population, strategic prioritisation, and purchasing directly using local knowledge of providers and contextual factors. The engagement of the stakeholder communities towards common goals of population health was also highly valued. There have also been some realities and constraints that the DHBs have needed to work within: financial status, capacity constraints, and accountability to central Government.

Over this period of DHB establishment the DHBs have developed skills to meet their primary objective of looking after the health needs of their resident population. At times this has included working collaboratively, driven by the need to achieve cost-saving efficiencies, by capacity constraints, and sometimes by the recognition that there are optimal levels of national/ regional /local delegation for different tasks and

functions. It is expected that this filtering out of the optimal level of organisation for different functions and collaboration over some tasks will continue to grow as the DHB system evolves further. By developing ways of collaborating the DHB can retain the valued local decision-making and also achieve necessary efficiencies for cost saving and to overcome capacity constraints. This can also be seen as the “grassroots” solution to the frequent criticism of there being too many DHBs.

The case studies all reported tension over the perceived barriers to local decision-making by central Government retaining control. There is a risk that too much central Government direction and rigidity in the reporting requirements set by the Ministry may constrain the innovations or flexibility with which the DHBs approach their tasks. Just as innovation and flexibility in contracting is encouraged by the development of relationships and trust between providers and DHBs, it could be expected that greater trust between central Government and DHBs may promote outcomes without compromising accountabilities.

## **8.2 With Regard to Governance**

### **8.2.1 *The Culture of the Board***

It was not possible to discern from this research what difference the culture of the Board makes to the performance of the Board, and in fact, what criteria would be the appropriate yardstick to measure that by.

It was observed that the Chair has considerable influence in setting the culture and the processes for the Board, including the style, mode of reviewing performance, agenda setting, relative organisation of the statutory committees, the degree of openness or inclusiveness. It was also evident that the culture varies between DHBs.

This raises questions about what represents “best practice,” and given the position of Chair is a crucial role, should it be an elected position or one that is appointed by the Government? If best practice guidelines were to be drawn up, should that be drawn up by central Government, for example, the Ministry of Health, or by the DHBs themselves, for example, DHBNZ? If this role is to be appointed the criteria could/should be made explicit. If it is to be an elected position, then should individual candidates campaign for that position?

### **8.2.2 Conflicts of Interest**

What is deemed “conflict of interests” varies between Boards. Some Boards found employees standing for the Board particularly difficult whereas others have developed protocols to cope with the issues raised. There is a trade-off between useful knowledge of the health sector and partisan experience/ interests. Experience from the case studies suggest there is a learning process over time on protocols and the appropriate focus of the Board as a whole.

### **8.2.3 The Election of Boards**

All cases studies reported a steep learning curve as Boards learnt their role and learnt to work with one another. The quality of the debate reportedly improved over time and there was some concern that the elections would have a de-stabilising impact. Should the electoral cycle be lengthened? These issues may be smoothed over time as those members continuing, or who are re-elected, provide a ballast of continuity to the Board.

The appointed members were widely appreciated for the supplementary skills and experience they provided. Particularly in the first round of interviews there were some concerns about the appointment process, suggesting these processes could be more transparent. Similarly the performance review processes for these members could be more explicit.

#### **8.2.4 *The Statutory Committees***

The Statutory Committees were found useful by the end of the research period but were also widely reported as problematic. It seemed the DHBs had to have them and so learnt to make use of them. Issues included their membership; boundary issues between individual committees, the Board, and management; confusion over whether the committees are advisory (therefore can act independently) or whether they are an agent of the Board; and the high costs associated with running these committees (members' time, costs of servicing the committees, inefficiencies created through double handling of issues). This raises the question of whether the topic of the Statutory advisory committees should be reviewed. The objectives the committees were intended to address could be considered against possible ways these could be achieved, e.g. a reference group of disability representatives, working groups on specific issues, or to continue a statutory committee with sharper definition of role and the membership determined according to the purpose. This could be facilitated by DHBNZ.

#### **8.2.5 *Board and Management Relationships***

The case studies varied in the degree to which management 'spoon fed' the Board recommendations compared to more challenging and directive Boards. There is no indication that one culture is necessarily better than another, although various Board members across case studies commented how they became more effective as Boards once they had learnt their role, usually measured by their ability to challenge management more. The Chair was identified as being particularly influential in setting the culture of the Board.

## **8.3 With Regard to Strategic Decision-Making**

### **8.3.1 Community Engagement**

What is the optimal role of consultation/ community engagement? In practice this is a multi-faceted concept and can be used in a number of ways with quite different objectives.

Getting issues onto the agenda is a key aspect of achieving attention on a particular issue of concern. This was sometimes controlled by the CEO and /or chair, but where members of the public can speak directly at meetings or at Statutory Committees then that provides a direct access. Conversely where public input is limited to consultation meetings, it is “after the event” in terms of agenda setting.

It is tentatively concluded that the public are more engaged by a culture of accessibility and active involvement in the meeting, as measured by public attendance at the meetings. This raises the research question though whether public engagement translates into the public adopting more health promoting behaviour or impacting on longer term outcomes.

### **8.3.2 Health Needs Assessment**

The HNA and prioritisation processes highlight the need for good research data, and that the absence of such data will act as a constraint. The HNA is also used to monitor progress but it also creates a pressure to research links between interventions and changes in health needs to provide the evidence needed for decision-making.

What are the risks arising from the loss of national continuity? How can these risks be mitigated?

### **8.3.3 *Prioritisation***

It is questionable whether prioritisation processes can be applied when DHBs are dominated by debt and when decision-making has not been fully devolved. An easing of the pressure to resolve debt within tight timeframes may allow more scope for prioritisation processes.

## **8.4 With regard to Finance, Purchasing and Contracting**

### **8.4.1 *Accountability for Deficit***

Feeling responsible for the financial status of the DHB clearly weighed heavily and dominated decision-making, particularly for Boards with a debt. Some of the case studies inherited debt or were at the mercy of historical spending commitments until those contracts ran their course. Holding Boards so tightly responsible can work against other objectives such as DHBs working collaboratively and cooperatively which is necessary for ensuring all have access to specialist services. While some DHBs have continued to provide tertiary services, there has been a clawing back from some other DHBs to minimise IDFs, and the tertiary hospitals have questioned whether the tertiary adjustor adequately compensates for the sunk costs, the high costs of service provision, and the degree to which tertiary centres tend to attract higher numbers of people with more complex health issues into the district.

### **8.4.2 *Getting Beyond Debt***

The preoccupation with debt is both a reality constraint for Boards and also an inhibitor to effective strategic decision-making where debt is present. It is suggested some bridging finance and financial solutions achieved over a transitional phase may ease the pressure and enable more optimal conditions for the Boards to function.

### **8.4.3 Safeguards for Non-DHB Providers**

The case study research has highlighted the funding difficulties for non-DHB providers: the relative power imbalance, the lack of funding for capital development and the vulnerability to the inherent incentives for the DHBs to favour their own provider arms (because of relationships within the DHB, the opportunities it allows the DHB to offset debt by overheads, familiarity with the provider arm, sunk costs, historical patterns of contracting, and the potential for bias within the Board towards the DHB's own services). Although there was no definite evidence of the DHBs favouring their own provider arms, there was widespread concern amongst non-DHB providers with some anecdotal evidence.

Given the concern around this aspect, are there any further safeguards which could be employed? There is also ambiguity about how the NGOs will fare in relation to PHOs which may exacerbate these concerns or may offer solutions.

## **8.5 With regard to Devolution and Sector relationships**

### **8.5.1 Reporting Requirements**

There was widespread disapproval of the reporting requirements amongst the case studies. The reporting requirements of the DHBs to the Ministry of Health could be negotiated, with DHBNZ representing DHBs' viewpoints. The advantages of this may be that reporting becomes more aligned to the DHBs' own purposes and more meaningful to the outcomes desired. It could also be tied into information management systems that are coherent, rational and feasible.

### **8.5.2 *The Role of Clinicians***

Clinicians were not surveyed systematically for their opinions of the health reforms. Tentatively it is concluded that relations between managers and clinicians have improved but this would need to be researched more systematically to be conclusive. This aspect is presumably one factor contributing to recruitment and retention trends.

What is deemed conducive to good relationship between clinicians and management included the opportunity for input on priorities; managers perceiving clinicians as fiscally responsible; channels, in some cases multiple channels, for input; Clinical Boards; including clinicians on the management board; transparency and openness regarding decision-making; and relationships established (though there is a tension between this objective and Funders and planners avoiding provider arm capture).

Clinicians' input into strategic decision-making is often filtered through several layers of decision-makers, which may overly dilute or distort their input. It was noticeable that the relationships between clinicians and the Boards were assessed as "distant" in a number of the case studies, and that this was deemed undesirable. There is possibly confusion between being subjected to partisan views and the need to avoid conflicts of interests in some Boards. Healthy, balanced dialogue with any concerned clinician stakeholders would seem desirable. Other considerations are the need to filter service investment considerations through prioritisation processes, and the inefficiencies of 'talk-fest' meetings using excessive amounts of personnel time for little gain. This aspect of governance may need further consideration.

## References

- Coster, G. (2000). Health Needs Assessment for New Zealand. Wellington, Ministry of Health.
- King, A. (2001). *Memorandum to the Social Policy and Health Committee*, [http://www.executive.govt.nz/minister/king/cabinet01-02/3\\_structure.htm](http://www.executive.govt.nz/minister/king/cabinet01-02/3_structure.htm). Feb 2001.
- 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.
- Peck, E. (1995). The Performance of an NHS Trust Board: Actors' Accounts, Minutes and Observation, *British Journal of Management*, Vol 6, pp135-156.
- Shortell, S. M and A. D. Kaluzny (1993). Health Care Management: Organization Design and Behaviour. New York, Delmar Publishers.