

**The new governance arrangements for  
the public health sector and the need  
for wider public sector reform**

*Len Cook and Robert Hughes*

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*The new governance arrangements for the public health sector and the need for wider public sector reform*

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## **Abstract**

Across the OECD countries the organisation of the public health service is subject to frequent scrutiny. In New Zealand there have been five major changes to the governance model for the public health service since the public finance and state sector reforms of twenty years ago. Reliance of politicians and public sector leaders on structural change may well continue. To anticipate the potential limitations and strengths of the reforms approved by the Cabinet in late 2009, this paper assesses the report of the Ministerial Review Group (MRG) and subsequent Cabinet decisions against seven themes relevant to improving the future capacity of public sector organisations.

A central conclusion of the MRG's report is the need for a new public health delivery model. To this end a key MRG recommendation is the creation of an independent National Health Board (NHB) to plan and monitor health service delivery through the District Health Boards. Consistent with this are proposals for the centralisation of some supporting functions and improved regional coordination. Cabinet has been more constrained in the changes eventually to be made. For example the NHB is an entity within the Ministry of Health. The Cabinet decisions also put in place initiatives to centralise support functions and improve regional coordination. However, little consideration is given to "consumers", who are at times patients, and the special relationship which exists between medical professionals and patients. From this perspective, the MRG's recommendations display strong managerial predilections.

This paper concludes that to improve the new public health service delivery model, additional changes will be required. These changes are centred on: (1) improving consumer/patient and health professional/patient relationships; (2) building from this the other elements of a supporting service delivery value chain, including appropriate structures and funding mechanisms; and (3) nurturing an allied and uniting continuous improvement culture able to bring about change to the entire health system through its components within the public, private and voluntary sectors.

## **Biographical note**

Len Cook is the former National Statistician for the United Kingdom and prior to that the Government Statistician for New Zealand. Since 2006 he has undertaken a number of reviews involving public administration in New Zealand, particularly health, as well as building on his interests internationally in official statistics. He is also a Senior Associate of the Institute of Policy Studies.

Robert Hughes is a career management consultant with particular speciality in the review and improvement of organisational systems. Before founding Hughes Consulting Limited in 1991 he was a partner in KPMG.

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## **Introduction**

### **Context of the Ministerial Review Group's report**

New Zealand has a small, dispersed population. Expenditure on public services as a share of GDP is high compared to most OECD countries. New Zealand also has a low rate of productivity improvement that pervades almost all sectors, public and private (the Treasury 2008; McCann 2009). There is recent argument that public services could deliver better value for money (Whitehead 2009).

Health spending in New Zealand had usually been at the lower end of those OECD countries to which New Zealand usually compares itself. Even though health spending in OECD countries grew significantly in this past decade, in New Zealand over this period growth in health spending was stronger than most. New Zealand's health spending as a share of GDP is marginally higher than the OECD average. Nevertheless, health expenditure per capita remains among the lowest (OECD 2009). It is assessing the benefits of this significant increase in spending on health over the past decade in New Zealand that has generated particular interest in the performance of the public health service.

The incoming National-led government commissioned a review of the health system in January 2009 to identify improvements that could be made without change to the District Health Board (DHB) structure. The report of the Ministerial Review Group (MRG), *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand* (the MRG report) was finalised on 31 July 2009. After considering the MRG report the Cabinet Social Policy Committee decided on a set of changes to the public health sector on 19 October 2009 (New Zealand Cabinet 2009).

The purposes of this Working Paper are, first, to assess whether the MRG report and the announced changes to the management of the health care system address critical issues facing the management of the public health service, and, second, to comment on whether further changes are needed. There is good argument that small size and remoteness are significant influences on New Zealand's lower growth in productivity (McCann 2009). To overcome these constraints New Zealand will need to focus intently on achieving economies of scale that are achieved more readily in larger countries. It will have to fight harder than other countries to which it compares itself with to achieve similar increases in productivity. This is recognised in our analytical framework, which is intended to pinpoint what should be key elements of such attention for the public sector.

### **Research question and method**

The central question posed in this study is: do the MRG report and the subsequent decisions by Cabinet provide a coherent set of changes that are likely to lead to sufficient improvement in the performance of the public health service, and if not, what are its deficiencies?

To answer this question we set out a general framework for the reform needed to improve performance in the public sector, and then compare the recommendations in the MRG report and the Cabinet decisions with that framework. The framework for the reform needed in the

public sector used for the analysis is based on Cook and Hughes (2009a). From that work seven themes for reform have been identified. A high degree of support by the recommendations and consequent cabinet decisions for each of the seven themes would be judged as providing a coherent set of recommendations/decisions. From this assessment we draw conclusions on whether the recommendations in the MRG report and Cabinet decisions will be sufficient to address the critical issues facing the public health service, and if not, the other changes that will be required.

Following this introduction the study is structured into four parts. The first sets out the framework for analysis. This is followed by an analysis of the MRG report and the Cabinet decisions, and then a discussion of the findings. The final part provides the conclusions from the analysis.

## **Framework for analysing the MRG report and Cabinet decisions**

### **Overview of the public health system**

Unease about how public health services can better respond to a mix of similar projected pressures is common among OECD countries, and it is generally recognised that there is no one single model for the delivery of public health services that is universally recognised as inherently superior. In ensuring the future capacity of the health services to meet a changing mix of demands, New Zealand is not alone in its search to better direct public health service resources. A greater focus on effective leadership of the public health service as a whole seems a common element of this. Since 1980 there have been four previous attempts at reforming the public health service by changing the overall model: at the start of the 1980s the model was 29 Hospital Boards running hospitals; 1983 saw the introduction of 14 Area Health Boards which combined hospital and other public health services; this was followed in 1993 with the move to 23 Crown Health Enterprises run under commercial disciplines and four Regional Health Authorities; then in 1996 these were replaced with 24 Hospital and Health Services with responsibilities for a wider range of health and disability services with a single Health Funding Authority; and in 2001, 21 DHBs were introduced with responsibilities for the provision (including purchasing these services) of publicly-funded health and disability services with funding provided through the Ministry of Health (New Zealand Parliament 2009).

There are significant anticipatable and avoidable risks to the future performance of public health services which stem from the current public health service delivery model; for example, concerns about patient safety and quality of services, increasing demand for services, the unsustainable funding, and issues with the public health management system.

### **Concerns about patient safety and quality of services**

Patient safety is an inevitable concern in any health system, often because information is incomplete at the time judgments are made. On occasion, this can be a result of systems



failure, or misjudgement.<sup>1</sup> The significantly increased monitoring, reporting and auditing of performance and events in health has resulted in system-wide information placing a high emphasis on adverse events, with little regular timely information on the performance and capacity of the health system as a whole to place adverse events in a relevant context. Much of the long-term value of the Health and Disability Commissioner's reports of adverse events results from the insights he brings on the systemic underpinnings of failures. Yet accountability for how these reflections are acted on seems to assume that responsibility lies primarily and substantively with the health professional rather than the systems they work with, deflecting fundamental concerns away from systems management and health policy itself. There is a risk that political leadership of responses in reaction to one-off events will lead to a series of unrelated, one-off resource allocation priorities focusing on short-term fixes rather than enduring solutions. For example, concern about patient safety becomes less well managed when it arises because a patient is unable to obtain the services they need due to intangible rationing processes that occur whenever there is a supply and demand imbalance. These risks are compounded when markets are fragmented by region and speciality.

Decisions about diagnoses and treatment often involve incomplete and even somewhat contradictory information, and the premises under which treatments have validity may not continue to hold over the period of treatment. As long as no trustworthy and understandable prior basis for recognising and assessing risk and uncertainty is easily available, then representing system performance by some selected patient outcomes may well lead to misleading conclusions unless there is comparison with similar cases. An overemphasis on generalising from selected individual outcomes can be expected where there is insufficient empirical basis for health services consumers to anticipate the chances of a return to original full health.

### **Increasing demand for services**

In New Zealand the main challenges to long-term resource allocation and capacity are the increased longevity of the population, changing health needs, and a broadening range of possible treatments, as well as shifting patient expectations. Although the rate of total population change in most centres outside Auckland is not large, and falling in some cases, quite significant shifts in the population age distribution in many regional centres are already underway. Increased longevity is adding to the years of disability-free living for most, with a better quality of life than that experienced by earlier generations. However, there are offsetting increases in the prevalence of some long-term debilitating conditions, of which diabetes is one of the most serious. Analysis of the current epidemiological evidence by the Ministry of Health (2008) concludes that the net effect of such influences on the demand for health services would lead to a net increase in the demand for public health services, although this is still somewhat uncertain (Christensen et al. 2009). Any such increase would be in addition to the growth in demand from changes in the size and composition of the population.

Reinforced by the advance of technology, a widening range of treatments is now available and this trend can be expected to increase for the foreseeable future. Often, the announcement of

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<sup>1</sup> These are reported on in the various publications from the Health and Disability Commissioner.

such treatments stimulates demand independent of medical assessments of the specific benefits to patients. In addition, a growing share of patients arrive informed and aware of medical conditions, and have strong expectations of all aspects of the care that they should expect. Advances in medical technology and increased expectations could markedly increase the demands on health resources both in the nature of the services offered and in the ways in which services are provided.

### **Unsustainability of projected expenditure growth from current health care models**

The long-term projections of spending on health in New Zealand show that the largest single factor which overwhelms all other considerations is the impact of rising incomes on demands for health services. This trend is well reflected in the experience across OECD countries (Hartwig 2008). As noted by the Treasury (2009), “The main drivers of health spending have been and will continue to be income growth and technological change – both of which affect the demand for, and the cost of supplying, health care.” In assuming that current trends would continue, Treasury project that health spending would grow by 5% a year, increasing from 6.9% of GDP (\$12.4 billion) in 2009 to 10.7% of GDP in 2050. This is a substantial cost for any nation and particularly one with low productivity growth.

### **Key issues with the current public sector management system**

These challenges and changes faced by the health sector are not unique to it, and are seen in other complex sectors such as justice, education and care. In our view there has been a general failure of New Zealand’s public sector management system to address their ramifications except through episodes of restructuring.<sup>2</sup> At a strategic level, the public sector management system has continually failed the health service in all four previous health sector management models that have been in place since 1980, in the following seven respects.

#### ***Key Issue 1: Insufficient formalised processes for establishing sector outcomes and overseeing the future whole-of-system performance***

The State Sector Act 1988 makes the individual institutions the focus of accountability, through the role of the Chief Executive Officer (CEO). The Public Finance Act 1989 reinforces this through the agency-level specification of performance measures and capital allocation processes. The funder/provider separation and the policy operations separation further reinforce this fragmentation. This strong emphasis on individual agencies generates little focus on how the sector in its entirety is involved in the delivery of public services. For the public health service there are a number of adverse consequences from this:

- a. The ability to provide effective **leadership of the complex system of entities (public, private and community) that makes up the service delivery value chain<sup>3</sup>** is

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<sup>2</sup> We have documented our reasons for forming this view elsewhere; see Cook and Hughes (2009a).

<sup>3</sup> A value chain is a network of capabilities which culminate in the capacity to deliver goods and services. For some of these service delivery value chains, the DHBs are important providers of capabilities. There is also a range of significant input value chains such as those involved in the training of medical professionals and the supply of pharmaceuticals (by the Pharmaceutical Management Agency of New Zealand (Pharmac)) and blood transfusion services. In the provision of public health services even the classification of relationships based on the provision of inputs and outputs is more complex than this.

constrained. This is seen in the limited nature of regional or national collaboration of clinical services, through the 21 DHB structure, despite many local successes. This is important because there are some global and national infrastructures that can improve the delivery of public health services, and these may be growing in extent. This is occurring at a speed faster than any single DHB can be expected to keep ahead of.

- b. In complex sectors of government such as in health and disability services, there is a need for accountability to be founded on clearly **defined outcomes that require inter-disciplinary cooperation**. The adoption by the previous government of outcome-based performance measures reflected more of an extension to output measures rather than fundamental goals that could measure the contribution of all in the health service value chain. This is evident in the longstanding arguments for integrated delivery processes for the aged, and for mental health care.
- c. In many areas we see political difficulty at a national and local level in addressing the location of any form of public services (e.g. universities). This is at its highest with clinical services. A national clinical services strategy was initially proposed in 1953<sup>4</sup> and little progress has been made since then. A somewhat ineffective tertiary services review in the mid 1990s attempted to develop a **framework of nationally provided services**. The impact of this lack of systems level political leadership means that there is potentially uneven access to and variation in the quality of some specialist services whenever any DHB has difficulty with the critical mass of activity regarded as necessary to sustain services most effectively. Oncology services for children and neurosurgery have been the most visible areas of concern, for what will undoubtedly be a much larger issue in the future. Where national services have been established, such as burns, it has been despite the absence of leadership at a national level.
- d. The output-based performance measures comparing year-on-year change generate strong incentives to **focus on achieving short-term gains** rather than the life-time impact or costs. One consequence has been the encouragement of investment in hospital buildings rather than population-based health change.<sup>5</sup> Other evidence is seen in the mixed focus on obesity, exercise and diet, certainly when compared to the recent efforts to tackle smoking and low immunisation rates in some areas.

There is a need to establish priorities in the context of shifts in the ways public health services are used, and the capacity to provide services over a long-term horizon. This requires formalised processes for establishing sector outcomes, and overseeing the future whole-of-system performance processes. For example, given the small size of the resource pool in New Zealand, these processes might need to be carried out centrally by the Ministry of Health or

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For example, Pharmac is also actively involved in the promotion of the good use of pharmaceuticals, especially antibiotics. The health sector also consists of a number of intersecting value chains, for example from welfare and insurance agencies. An illustration involving several public sector agencies is accident rehabilitation which could involve a DHB, the Accident Compensation Corporation, and Work and Income. Where these interactions are not well managed, the impact is to increase compliance costs on health professionals, increase competition of the scarce rehabilitation workforce and duplicate administrative resources.

<sup>4</sup> National organisation of health services was first proposed in the 1953 Committee of Inquiry into Hospitals in New Zealand.

<sup>5</sup> The report by the Central Region District Health Boards (2008) has provided analysis of over-investment in buildings in that region, which undoubtedly has relevance in other regions.

some other body. The extent to which this key issue is addressed by the MRG report and Cabinet decisions forms Theme 1 of our analysis in the next section.

***Key Issue 2: Absence of an effective governance body to identify core systems, inputs and outputs, and appropriate evaluation methods***

The New Zealand public sector has a well-established output monitoring framework. When assessing the performance capacity of institutions, systems and processes, measurement of past outputs is no substitute for the assessment of the effectiveness and efficiency of outcomes and key processes. There are a number of consequences of assessing the performance of the public health service using past outputs. In particular, there is very limited accountability at a political level for decisions about improving the use of system-wide resources and key systems that increase the scope of sector focused resources. Coupled with the emphasis on short-term efficiency, the focus is on past cost rather than the future capacity to maximise the longer-term mix of services that might be affordable given the prospective national income of New Zealand.

This failure to focus on dynamic and allocative efficiency dampens any drive for increased productivity from innovation, systems developments and quality improvement. This can best be seen in the opportunity cost of not centralising some support services by comparing to the benefits gained where this centralisation has occurred. Pharmac and the New Zealand Blood Service<sup>6</sup> provide good examples of the benefits of collaboration of centralising these two support services.<sup>7</sup> In addition, there is strong internal and retrospective emphasis on performance comparisons within and between current institutions which only serves to reinforce the status quo.

Key failings from the absence of a governance body to identify core systems, inputs and outputs, and appropriate evaluation methods are:

- a. Difficulties in managing the **later consequences of the long period of poor planning**, beginning in the late 1980s, of the number of doctors and nurses who need to be trained. The impact of this poor planning will continue for perhaps the next 15 years (Medical Training Board 2009; Cook 2009).
- b. It would be expected that the strategic level and managerial use of analysis of long-term demographic, social and health trends would provide the evidence base to inform and bring about shifts in the capacity to balance the supply and demand for health services, and the impact on institutions and services. **Political choices are often less well informed**. This has perhaps been most apparent in the continued failure to make long-term decisions about the regional dispersion of specialist services which should be provided from a few national centres of excellence. The past lack of long-term workforce management and the repeated dependence on restructuring of health organisations,

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<sup>6</sup> Pharmac and the New Zealand Blood Service are Crown entities charged respectively with selecting and purchasing government-funded pharmaceuticals, and supplying safe blood products collected from volunteer donors and the transfusion of blood products within the hospital environment.

<sup>7</sup> Why these institutions have worked well, and others of a similar form have not, needs to be studied.

and of the health system itself, provide even stronger examples of failing to use the evidence base that exists.

- c. Difficulty in **engaging medical professionals** in managing the ongoing tension between resource allocation decisions made at a population and health system wide level, with those focused on individual patient treatment and care (Callahan 2009; Ministry of Health 2009).

These key failings are identified in the MRG report.

To address these issues will require a governance body<sup>8</sup> with sector-wide authority to ensure that the health service as a whole has the future capacity to perform effectively in delivering outcomes over the next decade with the available resources, while investing in the capacity to meet the needs of the decade following that. The extent to which this is addressed in the MRP report and Cabinet decisions is Theme 2 in our analysis.

### ***Key Issue 3: Inadequate mechanisms for defining performance expectations for consumers***

The general inadequacy of New Zealand's public sector management system in addressing the complexity and breadth of decision making in sectors such as health and care has undermined the capacity of Ministers, the Director-General of Health, and DHB governance boards to develop and assert the mechanisms that link practice to policy. Consequently, policy decisions increasingly focus on process, so that the core working systems themselves become subject to the volatility and uncertainty usually associated with reactive policy.

The absence of robust analysis does not remove the need for political responsiveness to issues. Where political sentiment plays a larger part in policy choice and in the processes of delivery themselves, less opportunity exists for longer-term coherence in operational systems<sup>9</sup> that are designed for service delivery. Health sector outcomes are generally extrapolated from outputs rather than independent assessment of future pressures and opportunities. There is no broader target to keep in mind when directions seem confusing or lacking consistency.<sup>10</sup> An illustration of this failure was the public debate and subsequent judicial review of the funding by Pharmac of Herceptin. In his finding the Judge directed Pharmac "to fulfil its obligation to consult openly and fairly with those who have a legitimate interest in the ultimate decision".<sup>11</sup> Outside of Pharmac we are unaware of any specific requirement on the health sector to consult with parties who have a legitimate interest in the ultimate decision, insofar as improving the health delivery model is concerned.<sup>12</sup>

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<sup>8</sup> Whether this body should be the Ministry of Health or a Crown entity is not considered here.

<sup>9</sup> In most hospital settings, the taking of patient information by each of the series of clinicians who might be involved in assessing patient condition, diagnosis and identifying treatment remains a "pen and paper" operation, with potential risks and uncertainty to follow through.

<sup>10</sup> In our view, the funder/provider split and policy/operations split result in ineffective mechanisms to link practice to policy, in these circumstances (Cook and Hughes 2009b).

<sup>11</sup> A copy of the judgement can be found at <http://www.pharmac.govt.nz/2008/04/02/090408.pdf/text> (accessed 4 December 2009).

<sup>12</sup> There is the general requirement on health professionals set out in the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulation 1996.

From the perspective of the leadership of the public health service, consumer expectations could be incorporated into systems, processes and procedures with a supporting culture. This changed attitude to the place of the consumer might be reflected in specific programmes to increase health literacy in the community. Exactly how this is to be done forms Theme 3 of our analysis.

***Key Issue 4: Inadequate capacity for regular expert review of systems and performance, and defining best practice***

There are few processes for ensuring the on-going relevance of sector-wide incentives and processes for complex sectors of government. This reflects that few sector-wide bodies have any legal basis for their authority to have recognition by the Public Finance Act 1989 or the State Sector Act 1988. The three main agencies for such reviews have been the Treasury, the Office of the Auditor-General and the Ministry of Health.<sup>13</sup>

There is also some external benchmarking or external review of systems from a sector wide perspective, through regular benchmarking undertaken in the sector via the Australasian Health Round Table. Almost every hospital in New Zealand and Australia is benchmarked for most services along with outcomes, although this information is not regularly published. Currently the institution making the widest range of public assessments of performance is the Health and Disability Commissioner.

While dynamic efficiency cannot be easily measured in advance,<sup>14</sup> the pace of adoption of innovation can be measured and reported on for well-recognised core elements of the health system where improvements would have a significant impact.<sup>15</sup> This might well be, for example: the capacity for system-wide information exchange in patient, staff and diagnostic information; managed workforce capacity; common quality standards and best practice adoption; common accreditation criteria; common information architectures; common chart of financial accounts; single management of key supply chain elements; common standards for reporting quality, adverse events and other aspects of performance; and oversight of leadership development. Insufficiently strong leadership across this mix slows the pace by which performance in the delivery of public health services overall will advance.

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<sup>13</sup> The Long Term Strategic Framework being developed by the Director-General of Health offers considerable potential for filling this gap.

<sup>14</sup> We have concluded from our work in the public sector that insufficient attention has been given to retaining and organising the knowledge that the health service has from its operations, health research and population studies. For example, health care funding was recently doubled without measurement of the quality or effectiveness of the increased spending (Morton 2008). This is important because without a coherent understanding of the nature of the uncertainties faced, resource allocation will respond to the pressures for short-term maximisation of outputs from whatever resources are available, and under-invest in models of care, systems, skills and processes which would have a much greater impact beyond the current horizon of accountability. This is especially important now as, along with other OECD countries, in the next two decades it will be necessary to face up to an electorate increasingly impacted by the visibility of deficiencies and limitations in the public health service. The less that is understood about the uncertainties ahead and their influence on health service planning, the more will confidence in the health sector be undermined. In addition, a thorough understanding of the nature of the uncertainties and their probable relative importance is required to determine alternative organisational and contractual arrangements (Cook and Hughes 2009b).

<sup>15</sup> Examining past trends in productivity does not inform us about the potential for changing productivity, or the future capacity to perform.

Failures in this area are discussed in the MRG report. Our analysis assesses the extent to which the MRG report and Cabinet decisions address this issue in Theme 4.

***Key Issue 5: Insufficient legal and financial authority for cross-sectoral investment and governance***

Governance approaches within and around the New Zealand public sector management system are mechanistic and limited in our view. Governance is about having the authority to require that there is knowledge explaining why there are good reasons for what is being done and why it is being done in a particular way. There is no legal basis for sector-wide governance that has an authority comparable to that at individual agency level. There is thus little external authority for constructive challenge from a system leadership perspective of organisational forms, mix and direction in the health sector, either within any DHB or among them all as a group. In saying this, there have been a number of successes in leadership at a national level, such as burns treatment, but in most cases the initiative has not been led by any of the centralising bodies.

There has been a failure to have any health sector-wide body with the appropriate authority to focus on what is key to the future performance and scope of the health system as a whole. This makes it difficult to ensure the adoption by all in the system of key unifying systems and standards, and therefore extend the scope and resilience of services available from existing resources. The main exceptions to this are Pharmac and the New Zealand Blood Service as integrated national service providers.

This failure is identified in the MRG report.

Given the dominance of audit, monitoring and reporting that exists in health, getting things done regardless of the system may have become much harder, making it even more critical that governance works well in all its forms. The recommendations in the MRG report and Cabinet decisions to address this issue are assessed in Theme 5 of our analysis.

***Key Issue 6: Unsatisfactory leadership in the development of whole-of-government systems and leadership skills***

From the previous examples, it is not unreasonable to conclude that the current achievements of the public health service result more from the strengths and culture of individual institutions, and the commitment of health professionals, managers and support staff in their treatment and care of patients, than from the public sector system that it operates in, or any of the four health sector management models put in place by respective governments since the mid 1980s. The resilience that gets things done despite not having a supportive public sector management system probably reduces confidence in collective activity of any sort. It may have contributed to the great difficulty in achieving a timely consensus among DHBs on matters of real consequence to the long-term effectiveness and efficiency of the health system. This resilience is likely to have reinforced the fragmentation of services.

Compounding this, there has been little recognition among government organisations of the general applicability of concepts to reengineer value chains as a means of enabling clinical leadership to drive on-going improvements in the public health system. It is not clear that

hospitals and their support operations have made the best use of operational research methods and systems engineering practice applied in many fields.<sup>16</sup> Formal analysis of sector-level structures, systems and processes through microeconomic analysis ought to precede structural change, with weaknesses examined in advance of putting new structures in place, as well as application of well-accepted business concepts such as anchoring the value chain in consumer/patient expectations.

Given the geographic/population imbalance that New Zealand has, ideas from overseas cannot simply be imported. In addition, the stimulus of artificial competition that may work in a large urban conurbation of four million people may not have relevance for a total population of four million in a land mass greater than the United Kingdom. Poor choices made in the past have left several failings which are discussed in detail in the MRG report including:

- a. **Poor management of the relationship between the professional groups** embedded in the delivery of health care and the wider health system. The extension of skills among health professionals would be expected to necessitate periodic rethinking as to their relative roles in health activities, particularly as the systematisation and simplification of procedures is an increasingly significant consequence of information and communications technologies.
- b. There has been a marked **lack of standardisation on common supplies** that would enable economies of scale in purchasing, reflecting the total size of the DHB system as a whole. Underpinning this has been an apparent reluctance by central government to establish standards or oversee purchasing decisions, despite many opportunities for standardisation to have an impact on efficiency and effectiveness. This is most evident in the MRG's proposals for back office systems and the estimated gains of some \$500 million over five years. This implies that if this had been a policy from the time the Public Finance Act 1989 was put in place, some \$2 billion could already have been saved. In the early stages of New Zealand's public sector reforms, leadership in such collaboration was not even considered appropriate by the central agencies.
- c. Building up leadership capabilities depends not only on the innate aptitudes of potential leaders, but also the continual structured development of a **sufficiently large core of health professionals and others**, from each generation. This remains a failure of the New Zealand health system. (Medical Training Board 2009; Cook 2009)

These failures are discussed in detail in the MRG report. They could be addressed by instituting specific programmes to consider priority elements of the end-to-end public health delivery value chain. The extent to which these failures are addressed is Theme 6 of our analysis.

### ***Key Issue 7: Poor encouragement of innovation***

Effective responses to the challenges facing the public health service depend on: (1) long-term resource allocation decisions made at a political and managerial level; (2) clinical decisions

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<sup>16</sup> One of the exceptions to this is the recent initiative at the Canterbury DHB in elective surgery. This exemplifies the significant impact that systems engineering in medical-led processes can have on hospital performance.



made by doctors, nurses and other health professionals in treating individual patients; and (3) the health delivery model. There are notable instances of the ability within the sector to formulate effective responses by changing the delivery model and the sector has managed significant change over the past two decades. Illustrative of this are the continued change in the nature of health services provided through private sector, community and Māori organisations, and programmes to strengthen the recognition of personal behaviours on long-term health outcomes (for example, smoking). The capacity to manage change in health delivery models is seen in the implementation of the primary care strategy.<sup>17</sup>

Having said this, the ability to formulate effective responses has been difficult, because:

- The emphasis on shorter-term cost efficiency in the health sector may well have displaced a systematised focus on the efficacy of treatments adopted by health professionals (Callahan 2009; Wolfson and Lievesley 2007).
- The increase in resources allocated to health over the past decade has not led to comparable measurable gains in outputs and productivity (the Treasury 2005). Changed productivity in public health services is very difficult to assess.<sup>18</sup> Furthermore, over the last decade most additional resources have been directed by Ministers into a higher level of access to primary care, higher professional salaries and the management costs of the Primary Health Organisations (PHO) established in 2002. In addition, there has been a major redevelopment of hospital buildings in almost all DHBs which has required funding.

In addition, a foundation of distrust and aggressive contracting from the early 1990s often brought rigidity to relationships within and outside government that still affects constructive interaction and shared learning among different institutions. This diminishes the capacity to bring collective solutions to difficult issues, and stifles the spread of innovation. Assumptions of professional capture have led to limiting the involvement of high-level scientific, nursing and medical expertise in decisions. This was a poor substitute for enhancing methods of professional governance and engagement. The health system currently includes systems that are fragile and poorly defined. Encouraging innovation in high-risk, real-time environments, where errors have potentially catastrophic consequences, needs well-equipped and well-resourced change agents. The health system is at risk of being poorly prepared for the growth in external scrutiny and retrospective review, leaving professional workforces unnecessarily defensive about role delineation.

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<sup>17</sup> The nature of hospital treatment and where health services are delivered and resources placed have typified how the public health service may have changed more significantly than any other complex part of the public sector.

<sup>18</sup> While the concept of improving productivity provides a useful objective, productivity measures are poor at capturing improvements in services associated with better access or higher quality, and innovation is generally recognised after some delay. On the issue of the measurement of productivity see Atkinson (2005) and Wolfson and Lievesley (2007). We would also add that in the public health sector productivity depends on a wide variety of factors some of which may act differently (including perversely) on different parties. The public health sector well illustrates some of these: “The productivity measures being used to assess productivity are based on traditional units of count that no longer reflect the way that services are being delivered. For example we have so many services now being provided in the community or being done in outpatients that used to be done in hospital – these service changes are not reflected in any productivity measures that are used. The bottom line is that the system is using outdated and increasingly meaningless measurement tools.” (Personal correspondence from David Meates, CEO Canterbury DHB, 16 October 2009.)

Key failings in the encouragement of innovation are illustrated by:

- a. Locally, there is a strong capacity for innovation and commitment to deliver services in diverse circumstances, and some highly effective national services. Furthermore, there has been a **poor responsiveness across the system** as a whole to the depth and breadth of innovation, partly because of the disincentives for implementing system-wide innovation and systems, and the need to strengthen processes for defining best practice in the context of the public health service. This is evident in the limited capacity to readily exchange patient histories across DHBs. The impact of this is to require many clinicians to find and validate information on each occasion that a patient is seen in a setting different from where they usually go and this could result in increased risks of error from incomplete information and delay.
- b. The automatic return of depreciation to individual agencies reduces **opportunity of continuous re-allocation of capital base** and encourages innovation and investment focused on business units and agencies rather than at sector level (Cook and Hughes 2009b).

To address these failures would require organic processes enhancing the professionalism of health professionals to be put in place to promote innovation in the health service delivery value chain driven from the consumer/patient and medical professional/patient relationship. How the MRG report and Cabinet decisions address this is Theme 7 of our analysis.

## **Analysis of the recommendations in the MRG report and Cabinet decisions**

The proposals in the MRG report and Cabinet decisions which address each of these key issues are analysed below (to distinguish them they are referred to as themes).

### ***Theme 1: Formalised processes for establishing sector outcomes, and overseeing the future whole-of-system performance***

Our expectation is that there would be system-wide processes to establish service and resource management priorities that reflect expected shifts in the context in which public health services are used, and the capacity to provide services. Such processes would need to have a long-term horizon, focusing on the next decade in the context of the few certainties and potential uncertainties in the following decade. The MRG proposes creating the National Health Board (NHB) and enhancing the role of the National Health Committee (NHC) to undertake health technology assessment, as well as prioritise, in order to operate such processes. The MRG's proposal addresses this theme of public sector reform to a high degree and is adopted in the Cabinet decisions.

### ***Theme 2: Governance body to identify core systems, inputs and outputs, and appropriate evaluation methods***

We would expect such a governance body to have sector-wide authority to ensure that the health service as a whole performs effectively in delivering outcomes over the next decade with the available resources, while investing in the capacity to meet the needs of the decade

following that. Capturing economies of scope and other sources of economic advantage could ensure that the benefits that the health service could provide are available to all in all parts of the country. Sector-wide value chain management would address the way the health service interacts with other infrastructure to deliver health services, as well as the place and mode of operation of traditional institutions in the variety of regional and local settings. Significant candidates for system-wide value chain leadership are noted in Key Issue 4 above.

The MRG proposed the establishment of the NHB and Regional Committees of DHB chairs and CEOs. These bodies could promote and improve regional collaboration between existing DHBs but have no mandate to drive the benefits from taking a sector-wide perspective. The establishment of the NHB as a body within the Ministry of Health may be a pragmatic response, and with some supporting initiatives it could underpin effectively addressing core systems, inputs and outputs, and appropriate evaluation methods. It is not clear what would bring about the very necessary national coordination of provision of tertiary services such as cancer treatments and cardiac interventions, or lead the merger of DHBs when necessary to gain the benefits of size in providing clinical services. Given the long history of political inaction here, we assess this theme to be addressed to some extent only.

### ***Theme 3: Define performance expectations for consumers***

Consumer expectations of the health system reflect not only the experiences that they have had, but also expectations that there will be a capacity to meet their needs in later life. Judgments of performance need to include assessments of the prospective performance of system-wide investments, and whether their evolution reflects the emerging priorities of the system. Less overt is the continuing need to uplift the capacity for health systems leadership, with new skills required to deal with a higher level of integration of systems, commonality of practice, common purchasing from monopolistic supply markets, and a nationally managed community of scarce professional resources. There will be a need to establish and maintain international benchmarking for key elements (perhaps ten) of the health service systems and expectations of quality. Criteria for determining services that will need to be managed as national resources, wherever they may be located, need to be developed urgently and refined iteratively. While there is a good potential that the NHB, the NHC and the Ministry of Health working together could address this theme of public sector reform, the issue of consumer expectations needs to be explicitly addressed.

### ***Theme 4: Capacity for regular reviews of systems and performance, and define best practice***

Our expectation is that mechanisms would be established for the on-going review of delivery systems and their performance. The MRG does some of this by proposing the streamlining of some back office functions and highlighting the un-sustainability of the current model. The MRG's recommendation to establish a National Quality Agency (NQA) could meet our expectations of this theme, with respect to services. How such a body is established and the effectiveness of its engagement with the NHC and the NHB will be critical to its success, involving many yet to be defined elements. We say this because there are no explicit mechanisms for rooting the new health delivery model on the consumer/patient and medical professional/patient relationship.

### ***Theme: 5 Legal and financial authority for cross-sectoral investment and governance***

To deliver on these, our expectation is that the system governance role would have to be recognised through amendment of the Public Finance Act 1989 and other enabling legislation. The MRG proposes the establishment of a Shared Services Crown Agency, to streamline one of the input value chains, in addition to increasing the scope of the activities of Pharmac. Although the MRG does not provide mechanisms for sector leadership other than through the Ministry of Health, as a policy agency, the decisions of Cabinet are more pragmatic and maintain the operational focus of the Ministry. Without changes to statutes some changes will have reduced impact. The required changes would not be difficult to implement, but the experiences of shared services in the New Zealand government have been poor, primarily for the reasons of poor governance outlined in this paper.

### ***Theme 6: Focus in leadership development on whole-of-government sector systems and leadership***

Recent initiatives that advance this theme will be given a strong impetus by the new health workforce authority which is charged with training and leadership development across the health service. There remains a need for clearer, common recognition of clinical leadership roles within the DHB system, in particular the Chief Medical Officer (CMO) and Director of Nursing (DN) and their sector level leadership obligations. The Health Training Board is now in the process of establishment, and the need for related initiatives is widely discussed in the MRG report, including the need to find strategies for changing how different health professionals work together. The report also acknowledges that further work needs to be undertaken on the care of the aged and in mental health. The Cabinet sets up processes to implement the MRG's recommendations in these areas. The MRG report however, makes no recommendations for sector wide collaboration.

### ***Theme 7: Encourage innovation***

Our expectation is that success in this theme would be recognised by the mechanisms in place to promote innovation in the health service delivery value chain driven from the consumer/patient and medical professional/patient relationship. Applying innovations that are successful at a local level to health system-wide processes requires high-level governance, a relevant financial incentive system and a culture of continuous improvement. Whilst the MRG report emphasises the need for the involvement of clinicians and other medical professionals in operational and leadership decisions to improve the quality and quantity of services, no specific ways are identified as to how this will bring about a new health delivery model, other than through participation in the planning and management hierarchies. For example, one way this might be achieved is through a "clearing house" for innovations developed within PHOs and DHBs.

A summary of the assessment of the degree to which the MRG's proposals are consistent with the need for wider public sector reform is provided in **Table 1** below. This assessment shows that in the MRG report, two of the themes are promoted to a high degree and a further two to some degree. Three of the themes are not addressed in any detail. The Cabinet decisions bring the changes closer to what Cook and Hughes (2009b) argue is needed for managing complex sectors of government. However, even these do not present a coherent set of changes, and in

our view, additional changes will be required to improve management of the public health services.

The comments on additional changes required to reinforce the Cabinet decisions listed in Table 1 lead to the following findings:

- Managing the obligations to the public as consumers, and relationships with them as the subject of public health services, is not given any place in the conclusions of the MRG. This is especially the case in Theme 3.
- The new system continues to have weak mechanisms to drive sector-wide changes to the service delivery value chain. This mainly relates to Theme 6 but is also evident in Themes 2, 4 and 5.
- There has been little consideration of how a continuous learning culture will be developed, and its importance. This is identified in Theme 7.

For most organisations, consumers are their most important concern. The MRG report emphasises the need to change the delivery model and puts in place a set of government-centric institutional arrangements to do this, including appropriating health professionals into hierarchies. This is a managerial model of a health service in which some health professionals are co-opted into these institutional structures. This is not a model grounded in the public's health and the real-life relationships which occur between patients and health professionals. The MRG's recommendations and Cabinet decisions are not driven out of these real-life relationships to create a new model. The important finding here is that both the MRG report and the Cabinet decisions take a managerial, government-centric, top-down approach to developing a new model.

**Table 1: Assessment of the degree to which the MRG’s recommendations and Cabinet decisions are consistent with the need for wider public sector reform**

<b>Theme</b>	<b>MRG’s recommendations</b>	<b>Degree to which theme is met by MRG’s proposals</b>	<b>Cabinet decisions</b>	<b>Additional changes required to reinforce the Cabinet decisions</b>
1. Formalised processes for establishing sector outcomes, and overseeing the future whole-of-system performance	Prioritisation by NHC with planning by NHB and DHBs	To a high degree	Lead by Ministry of Health with prioritisation by NHC and planning by NHB and DHBs	
2. Governance body to identify core systems, inputs and outputs, and appropriate evaluation methods	Overall planning by NHB with input from NHC and coordination through Regional Committees of DHB chairs and CEOs	To some extent	Overarching role for Ministry of Health, with direction being provided by NHB, and coordination through Regional Committees of DHB chairs and CEOs	Focus in leadership development on whole-of-government sector systems and leadership will require regular leadership development programmes and clarifying the roles of CMO, DN and other professional leaders, including system-wide leadership
3. Define performance expectations for consumers		Not addressed		Mechanism to drive consumer and health professional/patient relationship through the whole service delivery value chain
4. Capacity for regular reviews of systems and performance, and define best practice	NQA	To a high degree but with reservations on whether consumer/patient focus will be attained	Proposed establishment of NQA	Capacity for regular review of systems and performance to ensure interaction with NHB, NHC and DHB leadership and supporting change in culture to anchor the service delivery value chain in the consumer expectations
5. Legal and financial authority for cross-sectoral investment and governance	Limited to implementation of Shared Services Crown Agency and the policy role of the Ministry of Health	To some extent	Greater role maintained for the Ministry of Health	Revise Public Finance Act 1989 and State Sector Act 1988 to enable cross-sectoral investment Introduce practical modifications that add flexibility to the operation of legislation, similar to UK
6. Focus in leadership development on whole-of-government sector systems and leadership	Limited to DHB provided services	Recognised but not addressed	New centralised processes within the Ministry of Health/NHB	Systematise whole of sector leadership development programmes. Clarify roles of CMO, DN and other professional leaders, including system-wide leadership
7. Encourage innovation	Through NQA and DHBs with participation in leadership by medical professionals	No details given	Not explicitly addressed but support for initiatives which increase clinical leadership and networks	Initial focus on system-level innovation will require clarity in systems direction, and engagement processes with relevant experts

## **Discussion**

### **Culture**

The underlying assumption in the MRG report is that the effective balancing of resources and demands for health will result from changes to the effectiveness of the operation of the health service itself. We have identified some additional critical influences. Firstly, health is unlikely to shift from the internationally consistent trend of being a form of luxury good in economic terms, in the way that could increase consumption of health services at a higher rate than our incomes rise. Given the extent of demographic and other influences on demand, there would be a need to consider the scope of the public health services, whether or not national income was relatively static for a long period. What is provided through a free public health service will be an increasingly difficult political issue. The involvement of the community and the private sector will be significant in the future, yet the place, nature and adaptability of such critical relationships need to be given considerable attention. Secondly, there is great uncertainty about how much living longer will impact on health services, yet the management of this critical uncertainty is left by the MRG to a few unusual comments about the value of those who live longer. There remain considerable differences in accessibility of health services by income, and this generates serious mal-distribution across New Zealand in the share of the national medical services accessible to particular communities, usually influenced by location, ethnicity and income. This has serious consequences for delivering programmes designed for all children, for example. Thirdly, the central theme of this paper is that all reforms will be constrained in their effectiveness by the current public sector management system.

There is a strong recognition of the value of strengthening patient involvement in the choices about their care. As newly formed or reformed central bodies, the NHC and NHB will need to establish strong processes of systematising consumer engagement in order to recognise shifts in patient preferences, and to assess their significance and consequences for their decisions. These bodies and their work and work methods will play a large and important part in establishing expectations, especially as the resources needed to provide choice to patients will be severely qualified by availability, which will affect regional and poorer populations in particular.

Māori and Pacific Island initiatives have been extensive, with Māori showing in the last decade a slightly faster improvement than Pākehā (e.g. it seems that life expectancy is now increasing a little faster for Māori, following a period of stasis in the 1980s and 1990s). The MRG report presents an ambiguous view of DHB and PHO responsibility for establishing models of care, and similarly the clinical and managerial engagement is ambiguous.

### **Process**

There is a well-recognised need for stronger clinical partnerships with managers. The obviousness of this, particularly in the light of the “In Good Hands” report (Brown et al. 2009), does not reduce the necessity to establish what it means. The MRG report focuses on clinician autonomy, and clinician failure. Implicitly, it embraces the nature of the engagement expected of clinicians, and the change needed in where doctors and health professionals are placed in the health system. The assessment of clinical outcomes is hugely critical to the cost effectiveness of the health service, yet expecting DHBs to write their own targets for this may be oversimplifying the breadth of interest in the efficacy and effectiveness of treatments, as

well as the efficiency with which they are carried out. There is a need for structured evaluation of the efficacy of treatments by the system as a whole which does not fit easily in the public sector management model, and which needs to be an ongoing process.

The MRG proposes that there be strong regional leadership and oversight of regional services by a council of regional board chairs and CEOs. This is not matched by a similar body at the national level, and it is not proposed that there be any change in the capacity of DHBs to lead the sector as a whole through informed and effective governance. The range of services that need to be examined for candidates as national or regional services is not large, and it is difficult to see why there need to be both national and regional approaches to assessing what is produced nationally, given the complex mix of influences that need consideration. The outcome may be to deliver any of the national services in selected DHBs only.

There may need to be some form of stimulus to encourage cross-DHB collaboration; for example, the three Auckland DHBs, Capital Coast and Hutt, Otago and Southland, the West Coast and Nelson Marlborough, Whanganui and Palmerston North. In terms of where to put the emphasis first, then it is most likely that establishing key nation-wide systems and standards should have the highest priority, along with determining what will be defined as national services for the next five years. The imperatives for doing this exist now. Continued lack of action will increase risks of inadequate supply of doctors to the New Zealand health service, and of insufficient capacity to provide vocational training.

There is a need to accept alternative models of engagement of doctors in the public health service, given the variety of contractual arrangements that are practiced, and the quite varying commitment of clinicians to bringing a leadership contribution that extends beyond their own patient management. Managers in the health service, as health professionals or experts in some other field, need to be effectively trained in the nature of health services and to continually have their capabilities extended through structured processes for continuing development. It is unlikely that professional training alone will give even the most talented health professional sufficient opportunity to develop the skills now recognised as essential for leading complex institutions. This needs to be overseen at the governance level, and systematised.

Changing the way services are provided may well slow the growth in demand for resources allocated to health, although initially investment may need to rise. Changing the nature of access to health services may tap into worthy unmet demand, and increase pressures. The MRG report proposals necessitate a strong Ministerial oversight and direction of operational investment and processes. Ministerial decisions on operational matters can involve expectations of reflecting political pressures that usually are not associated with commercial decision making, and bring tradeoffs that have other than economic considerations. Hence, they have an opportunity cost in terms of reducing long-run productivity. Outside the electoral processes, there is little challenge to the authority of Ministers that formalises an accountability to ensure that they enable the public to know that they have good reason for what they do and how they do it.

The MRG report acknowledges significant areas where common services could be established across DHBs, and proposes that a new national shared services bureau be established, fortunately reversing the poorly thought through received wisdom of the 1990s of Ministers and the Treasury that agencies should sort out all such things in their own way. Shared services require some strategic decisions not only about standards, but also about architectures



and DHBs have tended to make these decisions in isolation. In putting these proposals in place, it will be critical to distinguish those areas where common approaches would considerably extend the future scope and adaptability of public health services, given fixed resources, and those areas where costs overall will be more effectively managed, but no significant shift in the nation-wide capability of the service will occur, through such economies of scope. The governance of shared services entities has had a poor history in the public sector, although considerable learning is possible from the experiences. For example, back office integration involves not only commonality of standards, but also common information and communications architectures. It is a pity it has taken so long to give this the prominence it now has, but equally it is important to recognise the need for considerable care in selecting what to focus on. The need for changing the Public Finance Act 1989 may slow putting this in place.

The considerable emphasis placed on quality will be greatly welcomed, although quality improvement seems to be perceived as a matter of individual performance and teamwork rather than an attribute of a learning system. The MRG report suggests that the financial incentives on DHBs may lead them to under-invest in safety and quality. A comprehensive focus on quality improvement needs to embrace systems, culture, practices, standards, compliance mechanisms, relevance and transparency. Quality investments span the whole gamut of the DHB capital base. Rather than deliberate under-investment in quality and safety, the usual experience in public services that have attempted to maintain service levels in the face of cuts in resources is that unintended quality cuts occur that are rarely transparent.

Quality is an ever-present attribute that results as much from resource allocation decisions made at any of political, strategic, managerial or operational levels, as it does from mistake, or misjudgement. It may be that the perceptions of blame associated with failure in fact reduce innovation, and limit treatment options considered for some patients. Many of the attributes of quality are not self reinforcing, but may be in conflict, so that quality management continually involves difficult judgments reflecting the circumstances and a wider context, that may be difficult to replicate in any retrospective review.

Increased teamwork will not necessarily involve all health professionals, and needs to be reinforced by good system investments. Quality leadership is pervasive, and giving it to a national quality agency may create a sense that others are less involved, and limit how we define it. Each institution will develop its own means of justification, and the justification at an institution level may not be consistent with the best interests of the health service as a whole, without specific governance arrangements. The power of effective quality management is well articulated by the MRG, as is the value of the information and processes in enhancing productivity as an additional outcome from improved patient safety. More prominence would need to be given to the linkage between the quality of systems and processes used within and across DHBs, recognising that it is the systems that are constantly referred to by the Health and Disability Commissioner, as the source of quality concerns.

The essentiality of a common patient record is argued for. A common transferable patient record is partly an IT matter, but more significantly it underpins the integrity and effectiveness of a nation-wide health service required to support a mobile population throughout their lives, wherever health care is delivered. The focus on common records needs to expand to staff information. The patient record must be able to allow near immediate access to any diagnostic information wherever and however obtained, which may necessitate not only rigorous adherence to national standards, but acceptance of particular technical and

architectural specifications across diagnostic processes. The DHB-wide leadership of the health service needs to be able to determine this, and enforce its decision.

## **Structure**

Changing the mix of DHBs is often seen as essential to improving the health system. Making small changes to the number of DHBs would have much less consequence than changing the way in which decisions that involve several or all DHBs at once are made and adopted. The political difficulty of where to locate medical services needs some clear national strategy and leadership to manage, but doing this in the midst of some specific crisis, such as paediatric oncology in Wellington, will not generate effective long-term solutions. Central to delivering health services to populations that cannot see a local capacity near their doorstep will require greater flexibility in service models, much more information about health services organisation, richer engagement with community leaders, and a highly managed integration of health services with information, communications and transportation services that are part of any value chain. The large hospital could increasingly become just one of the places of work for medical specialists. In this regard, leadership of the health system and its governance is far from effective, and poorly supported by the New Zealand public sector management system. Any additional institutions will need definite authority and sound engagement with DHBs to change this.

New models of health care are seen as of great significance. Building on the significant shift in the amount of care delivered outside the hospital system, this change will have to continue. For example, some 50% of nurses now work outside hospitals compared to fewer than 20% some 25 years ago. As this shift advances, there will need to be greater recognition of the part of sectors and organisations outside the health system in assessing models of care. Despite these past and prospective shifts, there continue to be insufficient means of effecting changes in roles of health professionals that would coherently bring about a significant increase in the adaptability and capacity of the health workforce, and help make future health services less vulnerable in the face of projected growth in demand. Strong evidence has existed for some time for new models of care in areas such as diabetes, and a wide array of initiatives exists, but establishing nationally-cohesive approaches is less a matter of will than capacity to provide system-wide leadership. Future models of care are certain to see an ever increasing role for population health initiatives, a strengthening of primary care, and new funding models. Population health initiatives usually have a payback period much longer than the electoral cycle, while costs are usually up front, making the benefits less politically attractive to voters unless there is an unusually high degree of public awareness. Future models of care will require strong partnerships and relationships, yet the rigidity of the contractual focus of relationships generated by the New Zealand public sector management system has often lessened trust between government agencies and those they contract with.

The NHC is to be strengthened and given more authority in its work. The NHC has been judged by the MRG to have been a successful component in the current health system arrangements, with a strong capacity to bridge the professional/ political tensions in resource allocation decisions about health services. The decisions of the NHC in its proposed extended role would have major implications for the delineation of national services and their location, as well as the nature of the health sector's system-wide core infrastructures and standards. The effective collaboration on these issues by DHBs and the NHC could strengthen the coherence of key decisions made within the health system, about what services and where and how they would be delivered. The NHC would have the capacity to bring a system-wide view to

potential developments in the health system and play a major part in uplifting strategic thinking in the health sector. It will be NHB decisions that ultimately increase the scope of New Zealand's public health service system, whatever the available level of resources, and the quality of NHB decisions will depend on the capability of the NHC in understanding the likely pathways for health system services and investments.

### **Cabinet decisions to modify the DHB model**

The establishment of the NHB and its external governance board within the Ministry of Health brings a pragmatic resolution of several tensions that currently prevent action. Interchange of staff with other health sector bodies will be essential, and regular monitoring should be secondary to the capacity to lead periodic reviews of significant sector issues. The Director-General of Health is a role of longstanding significance in the system that goes beyond supporting and informing the Minister of Health in his strategic and operational oversight of the health system resulting from the new arrangements. The trustworthiness of the health system in times of major challenge, from pandemic through to adverse event management, will rest ultimately on the capacity of some single objective voice speaking with authority on health matters. Through the nature of their appointment, and their place and role in the past, it is the Director-General of Health who uniquely fills this role, but its significance seems poorly recognised in the MRG report.

The Ministry of Health must retain a capacity to manage serious health events that are likely to have national importance, such as the swine flu pandemic. A residual capacity for contingencies is inevitably found by redeploying existing resources, rather than maintaining a capability on a contingency basis. As its current tasks become reassigned, there is a need to maintain a future capacity to lead in these situations. Existing criticisms of how the Ministry engages would be reduced as long as the proposed NHB, and the NHC, engage effectively, and do not develop practices which seek to reinforce their own role rather than the performance of the sector. All the performance goals of these bodies need to be expressed through the performance of the sector as a whole, with the demonstration of short-term goals being balanced by the less tangible capacity to provide assurance of good decisions being made about the longer term.

### **The changes and the need for wider public sector reform**

Health is a complex sector, continually changing in the mix of demands placed on it, and in ongoing innovation that is changing the knowledge and capability to provide health services. Alongside this, public expectations become more exacting, particularly in expectations of an immediacy and cohesiveness in the parts all play in health services. There are no known ideal models with which to fashion an improved system in New Zealand, and past long-term investments made in buildings, technologies, skills and relationships continue to shape our capacity to respond to changing conditions. Many of the investments made have to remain useful long after there is any certainty of what the needs will be.

There are tensions in managing national health systems that seem to have been relevant in New Zealand particularly over the past two decades. The interaction of the various sources of complexity means that there is a need to recognise a huge degree of uncertainty in how the inevitable pressure from population change, innovation in diagnosis and treatment, staff availability and fiscal constraints will evolve. To cope with this, the health system leadership must be able to provide the capacity, knowledge and wisdom to steer us along a new path.

The health system in New Zealand is dependent on the public sector management environment, in the laws, accountability structures, institutions and ethical underpinnings of its work. It is also reliant on non-government organisations, both community and commercial, to provide a huge array of services from diagnostic services to home care. The inter-relationships between government and these non-government organisations are themselves continually evolving, and potentially provide the source of much innovation in health. The greater the capacity of each party in these relationships to shift their part in the delivery of particular services, then the more the system as a whole can innovate and adapt without continual institutional change. We have argued that there are serious flaws in the New Zealand public management system, and that these flaws have their most serious impact on sectors of government that are complex and which involve many government bodies as well as community, commercial or local government. The sectors of government most affected are health, justice, education and care. In these sectors it is argued that the institutional and accountability arrangements have brought rigidities at a sector level that have made these systems cumbersome, unresponsive and much less innovative. Linkages between policy and practice are often poor, and lead to increased Ministerial directions of processes, often without consequent managerial accountability.

Because health has been subject to quite dramatic organisational change over the past two decades, the accumulation of past policies will have a residual influence on the way new policies can be delivered. Each unsuccessful attempt at reforming the public health sector has been through the imperatives of political action. This naturally subjects any new approach to doubt about how long any new model will stand the test of future political change. This paper suggests that a richer, analytically-based perspective on the way our health system is organised may provide a stronger basis for political consensus and more appropriate forms of ongoing governance in such an area of continually high political engagement.

## **Conclusion**

A central theme in the MRG report is the need for a new public health delivery model. A key MRG recommendation is the creation of an independent NHB to plan and monitor the health delivery service through the DHBs and consistent with the centralisation of some supporting functions. The Cabinet decisions are more measured in the changes made; for example, the NHB is an entity within the Ministry of Health, and puts in place initiatives to centralise these support functions. Little consideration is given to consumers, and the special relationship which exists between medical professionals and patients. From this perspective, the MRG's recommendations have a strong managerial focus. In this sense, the MRG has continued a tradition starting in the late 1980s of basing reform of the health sector on structural change.

This analysis finds that additional initiatives to those in the Cabinet decisions will be necessary to develop a new public health delivery model. These changes are:

- improving consumer/patient and health professional/patient relationships;
- building from this the other elements of a supporting service delivery value chain, including appropriate structures and funding mechanisms; and
- nurturing an allied culture of continuous improvement in the value chain.

To achieve this will require better system-wide leadership. There are no quick fixes within the health sector, because health systems are both complex and continually evolving. Any change should be well founded on redesigning the value chain from end-to-end, starting from the consumer and medical professional/patient relationship.

The health sector has a propensity for generating reports on some issues such as workforce, but few of them have generated action, regardless of their quality. Under the structural arrangements, managers in the public health service have difficulty making decisions about the health system and this has resulted in many decisions being left to Ministers. While political, public sector administrative, health professional and service delivery operational leadership all impact quite significantly on the effectiveness of the health service, it is perhaps surprising that it is mainly administrative and operational decisions that have been assessed in the MRG report.

New Zealand has a comparatively small population, with a generally well-regarded health service, and although it is well recognised that the public health service faces a demanding future, decision making in the current national health system to bring about higher productivity and greater long-run effectiveness has been unduly slow. To speed up this rate of change some structural elements are being changed. Long-term sustainability will, however, rely on internally-generated change from continuous learning. The MRG report and Cabinet decisions build no mechanisms for this. We predict from this that the health sector will be subjected to further Ministerial imposed restructurings.

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