



Health Reforms 2001 Research Project

Report No. 4

**FINANCING, PURCHASING AND
CONTRACTING HEALTH SERVICES**

Toni Ashton

On Behalf of the Health Reforms 2001 Research Team

August 2007



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Introduction to the Health Reforms 2001 Research

In 2001, the New Zealand government introduced reforms to the structure of New Zealand's health and disability sector. Under the New Zealand Public Health and Disability Act 2000, the government introduced a number of overarching strategies to guide the health and disability sector and it established 21 District Health Boards as local organisations responsible for population health and for the purchasing and provision of health and disability support services at a local level.

In 2002, funding was provided to chart the progress of, and to evaluate, these reforms as they were implemented. The research took place between 2002 and 2005. This paper is one of a series reporting on findings from the research. The papers in the series focus on:

- *Health Reforms 2001 Research: Overview Report*
- *Governance in District Health Boards*
- *District Health Board Strategic Decision Making*
- *Financing, Purchasing and Contracting Health Services*
- *Devolution in New Zealand's Publicly Financed Health Care System*
- *Māori Health and the 2001 Health Reforms*
- *Pacific Health and the 2001 Health Reforms*
- *Overview Report of the Research in Five Case Study Districts*
- *Print Media Reporting of the DHBs*
- *Performance of New Zealand's Publicly Financed Health Care System: A Focus on Performance Under the New Zealand Public Health and Disability Act (2000)*
- *Public Sector Management and the New Zealand Public Health and Disability Act*

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Executive Summary

This report documents the processes associated with financing, purchasing and contracting health services under the NZPHDA model. It assesses the strengths and weaknesses of these systems, and makes some comparisons with previous models. An assessment is also made of the extent to which these funding mechanisms are contributing to the overall objectives of the NZPHDA model, and to the desire to reduce the commercial focus of service providers that developed during the 1990s.

Research methods

Research methods comprised two rounds of interviews in 2002 and 2005 with: national stakeholders (including Ministers, Ministry officials, and representatives from national provider organisations); all DHB CEOs, Chairs, and Planning and Funding Managers; the four Shared Services Agencies and Regional Mental Health Networks; and key informants from five case study DHBs, including NGOs and community representatives. The research also draws on any relevant (published and unpublished) documents and statistics.

Historical context

Financing, purchasing and contracting under the NZPHDA has emerged from a series of reforms in the health sector over the past 20 years. Prior to the establishment of area health boards (AHBs) during the mid to late 1990s, hospital boards were funded by fixed annual budgets determined largely on a cost-plus basis. In 1983, establishment of AHBs commenced, and the first population-based funding formula was introduced to reflect the health care needs of the different regions. However, implementation of population-based funding was slow and regional inequities persisted. From 1990, in return for their share of government funds, each AHB was required to sign a 'contract' with the Minister which specified the range of services they planned to provide together with a set of performance indicators. The Department of Health also contracted directly with a number of large NGOs during this period.

From 1993, separate organisations became responsible for purchasing and providing services. Funding for all personal health and disability services was pooled and both public and private service providers were required to contract with the Regional Health Authorities initially, and later, with the Health Funding Authority. The 1993 reforms reportedly brought improvements in accountability, but there was little evidence of efficiency gains. The competitive approach to purchasing increased fragmentation, led to more acrimonious relationships and sometimes undermined quality where attention focused on financial rather than clinical performance. The NZPHDA has brought a return to population-based funding for DHBs which provide some services directly via their provider arms, and contract for other services with non-government service providers.

Population-based funding and inter-district flows

The funding of DHBs on a population basis is in line with the general objective of encouraging a population focus in the health sector as outlined in the New Zealand Health Strategy. The overall view of our respondents was that funding via the formula is likely to result in a more equitable allocation of funds than funding via contracts. However there are concerns about the quality of some of the data used for determining funding allocations, and about lack of compensation for unavoidable cost differences across DHBs. If there are inherent differences in the cost of service provision, inequalities in access to services across DHBs may be perpetuated.

The existence of 21 DHBs means that there are numerous inter-district flows (IDFs) of patients. This introduces uncertainty and risk, especially for the larger DHBs which provide more specialised services. We heard anecdotes of out-of-district patients who had been denied access to services. Other problems with IDFs included poor quality data on the numbers and types of flows; inaccurate pricing; and late payments. IDFs are also costly to monitor and administer.

Devolution of contracts to DHBs

The process of devolving contracts to DHBs was problematic. There were long delays in getting access to copies of some of the contracts, inaccuracies in the contracts, and insufficient information to allow DHBs to undertake due diligence.

As a general rule non-government providers prefer contracting with a local purchaser rather than with the HFA or the Ministry. However, purchaser-provider relationships are uneven, with negotiations and systems being driven by the DHB rather than by working together in a partnership with providers. Opinions are very mixed about whether funding for public health services and disability support services for people aged less than 65 should also be devolved to DHBs. Overall, the case for further devolution of funds seems stronger in the case of disability support services than it is for public health services.

Choice of provider

The allocation of funds between public and private providers is affected both by the selection of providers by DHBs as purchasers, as well as by any general shifts in patterns of service provision over time towards community-based care. With respect to choice of provider, DHBs clearly have the intention of treating their provider arms as ‘just another provider’. However, in practice this may be hard to achieve and there is widespread perception amongst NGOs that DHBs tend to favour their own provider arm over non-government providers when allocating contracts. NGOs would find it useful if each DHB developed a policy that outlines how they plan to deal with private providers.

Contracting issues

Style of contracting: Over the period of our study, the general trend was towards more user friendly, less bureaucratic, longer term contracts. Problems can arise in cases where DHBs are required to honour a contract where key aspects of service development and/or the contract (including the price) has been negotiated by the Ministry or another DHB. This generally occurs in regional or national contracts but has also occurred in contracts with local providers, particularly Primary Health Organisations.

Capital expenditure: Some NGOs are concerned that their contracts with DHBs do not include any allowance for capital expenditure or service development. A lack of funding ear-marked for capital expenditure may encourage some NGOs to draw down on their operating expenditure so that either the quantity or quality of services provided may be undermined over time. There is also a perception amongst NGOs that the lack of capital funding is inequitable because, while DHBs receive capital funding from the Ministry, NGOs do not.

Monitoring, auditing and reporting: Monitoring of contracts is a key mechanism for minimising risk. While both DHBs and providers have encountered problems with monitoring and audit procedures, these procedures have picked up cases where providers have failed to deliver according to the contract but the problem had not previously been picked up by the Ministry or the HFA. Some providers expressed dissatisfaction that, in spite of improvements in monitoring processes, these often still do not capture all relevant aspects of service delivery.

The roles of Shared Services Agencies and HealthPac: The roles of the SSAs sometimes include negotiating contracts with service providers and general management of the contract. Some NGOs have found this involvement of a third party in the contracting process rather complex, with the lines of accountability becoming blurred.

HealthPac acts as an agent for the DHBs in processing claims for subsidies, payments for contracts, and in managing and co-ordinating contracts. This process has not always been running smoothly. Information about services provided is sometimes inaccurate or incomplete, and deadlines for DHBs to complete the contracting process with HealthPac are often very tight. These difficulties with contracts and payments have caused tensions between the DHBs and HealthPac, and some DHBs expressed frustrations with HealthPac's role.

Financial management by DHBs

There was clear understanding amongst DHBs that the government expects DHBs to live within their budgets and that the Minister would accept "*no excuses for over-spending*". The need to reduce deficits therefore tended to dominate DHB decision-making in the early years, to constrain innovation and to focus attention on short term solutions rather than on long term planning. However over time, the focus shifted towards a longer term view of financial management. Some boards reported that the Ministry had been helpful in working with them to find solutions to their deficit problem. Others had problems in achieving Ministry approval for the rationalisation of facilities and services. The announcement of a three-year guaranteed funding stream in December 2001 provided an important degree of certainty and allowed DHBs to develop strategies for the removal of their deficits. The move to population-based funding also assisted some DHBs to reduce their deficits.

An assessment

The move to local purchasing and contracting by DHBs under the NZPHDA model is generally regarded as preferable to centralised purchasing because it allows greater responsiveness to local needs and preferences. Purchaser/provider relationships have become closer with local purchasing. However an imbalance of power between the purchasers (i.e. the DHBs) and non-government providers is still very apparent.

Major problems associated with the transfer of contracts from the Ministry to DHBs stimulated DHBs to examine the contracts in some detail. Many discrepancies were identified and in some cases, significant savings were made. Monitoring and audit of contracts is improving and purchasing decisions are becoming more transparent.

Are funds being allocated fairly across DHBs?

Funding via a population based funding formula is more equitable than the previous system of price and volume contracting. However, concerns remain about inequities in funding due to (a) differences in the cost of providing services across the DHBs, and (b) deficiencies in payments for inter-district flows, primarily due to information about flows of patient for non-inpatient services.

Is the system refocusing away from costs and more on outputs and outcomes?

For DHBs with significant deficits, cost remains a driving factor in the decision-making process. How the general improvement in the financial position of DHBs over time, together with the development of more systematic and balanced methods of setting purchasing priorities, have resulted in more balanced decision-making processes which take a wider range of factors into account.

Are the methods of resource allocation contributing towards reducing health disparities?

The aim of encouraging DHBs to focus on the population living within their district may have the unintended effect of reducing the priority that a DHB places on services provided to out-of-board patients, particularly where that DHB has funding constraints. Disparities may also be perpetuated if some DHBs have *unavoidable* higher costs and consequently are unable to provide the same level of service as other DHBs.

Is there a level playing field between public and private providers?

Because DHBs are both purchasers *and* providers, they may not be as neutral in their purchasing decisions as the HFA. This suggests that some central monitoring of purchasing patterns may be desirable.

Has competition for funds been reduced?

The aim of reducing competition for public funding by public hospitals has generally been achieved. However, there is still real competition for funds both between public and private providers, and among NGOs.

Are longer-term funding arrangements being made with organisations that perform well?

The development of a three-year funding stream has allowed the DHBs to plan further in advance and to negotiate longer-term contractual arrangements with many providers. However, the threat of non-renewal (and sometimes termination) of a contract remains for many non-government service providers.

1 Introduction

The central feature of the New Zealand Public Health and Disability Act (NZPHDA) model has been the establishment of the 21 District Health Boards (DHBs) which are responsible for purchasing or providing health services for the populations residing within their geographically-defined areas. Devolution of the responsibility for purchasing or providing health and disability services from the Health Funding Authority to the 21 DHBs via the Ministry of Health¹ has necessitated the development of numerous processes for allocating resources and for tracking the flow of funds through the system. These include:

- determining the share of funds to be allocated to each board;
- managing DHB budgets;
- devolving current contracts from the centre to the DHBs;
- negotiating, writing and monitoring contracts with non-government providers;
- transferring funds between DHBs for patients who are treated outside of their board of domicile;
- monitoring the DHBs' financial performance.

Changing the methods of allocating funds across the country is intended to contribute to the four broad objectives specified in s.3 of the NZPHDA. These are (in summary):

- (a) to improve, promote and protect the health of all New Zealanders, to promote inclusion and participation of people with disabilities, and to achieve the best care and support of people in need of services;
- (b) to reduce health disparities;
- (c) to provide a community voice in matters relating to health and disability support services;
- (d) to facilitate access to and dissemination of information to deliver appropriate and effective health and disability support services.

¹ Responsibility for purchasing and contracting for services was transferred from the Health Funding Authority to the Ministry of Health as a temporary measure until the 21 DHBs could be established..

The health policy of the Labour Party prior to the 1999 election (New Zealand Labour Party 1999), which underpinned the NZPHDA model, also indicates that there was a desire to:

- restore a non-commercial system and focus on the provision of quality services;
- replace competition among providers with collaboration;
- avoid routine contestability of funding for hospital services;
- secure long-term funding arrangements for organisations that have a history of provision of quality services;
- develop partnership relationships with NGOs rather than purely contractual arrangements.

This report documents the processes associated with financing, contracting and purchasing health services under the NZPHDA model. It assesses the strengths and weaknesses of these systems, and makes some comparisons with previous models. It also makes an assessment of the extent to which these funding mechanisms are contributing to the overall objectives of the NZPHDA model.

1.1 Research Methodology

This report is one component of the Health Reforms 2001 Research Project, a three year project undertaken to chart the progress of, and evaluate, the health reforms enacted by the New Zealand Public Health and Disability Act 2000. The objective of the research project was to document, comment on, and assess the strengths and weaknesses of alternative ways of organising strategic decision-making, governance, purchasing and accountability arrangements which develop under the Act. 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 wider research project comprised a range of different methodologies. This particular component of the project utilised the following research methods:

- Key informant interviews with national stakeholders including Ministers, Ministry officials, and representatives from national provider organisations;
- Interviews with all DHB Chief Executive Officers (CEOs), Chairs, and Planning and Funding Managers.
- Interviews with the four Shared Services Agencies and Regional Mental Health Networks;
- Five case study DHBs which included interviews with: selected board members and senior managers; representatives from PHOs, NGOs and other key private providers, local body organisations and community-based interest groups.

Two rounds of interviews were undertaken in 2002 and 2005. All interviews were semi-structured and, in most cases, face-to-face interviews were conducted. If face-to-face interviews were not possible for any reason, interviews were conducted by telephone. All interviews were tape-recorded and transcribed verbatim. A series of 'base reports' were then written up covering each category of interviewees plus each of the five case studies. This report is based upon information from both the original interview transcripts as well as the base reports. It also draws on any relevant (published and unpublished) documents and statistics.

1.2 Outline of Report

To place the issues into context, the report begins with a brief review of some of the changes that have occurred in methods of allocating resources in recent years. This includes the development of agreements and contracts between the Department of Health and purchasers during the late 1980s and early 1990s, as well as contracts between purchasers and providers following the purchaser/provider split in 1993. The next section is devoted to the issue of allocation of funds to DHBs via the population-based funding formula and inter-district flows. The incentives associated with these funding mechanisms are discussed and some consideration is given to the potential inequities that may arise.

In Section 4, we examine the problems and issues associated with devolving contracts to the DHBs. We also discuss whether further devolution of funds for public health services and for disability services for people aged below 65 years is desirable. Section 5 is devoted to issue of choice between public and private providers. The question of whether the NZPHDA model contains any inherent bias towards DHBs is discussed, together with issues associated with shifts in the allocation of resources over time because different types of services are provided by the two sectors.

In Section 6, we examine some of the issues associated with contracting between DHBs and NGOs including the style of contracting and the role of Shared Services Agencies and HealthPac in the contracting process. This is followed by a brief discussion of the financial position of the DHBs and the management of their deficits. The report concludes with a summary of the key findings, together with an assessment of the extent to which the funding processes are contributing to the objectives of the NZPHDA model.

2 Historical Context

Prior to the establishment of area health boards (AHBs) during the 1980s, 27 hospital boards were responsible for the provision of secondary and tertiary services and some community care, while primary health services were funded separately by the Department of Health, primarily on an open-ended fee-for-service basis. Public health services (i.e. population-based preventive services) were also funded and provided separately via district offices of the Department of Health (Gauld 2001). The hospital boards were funded by fixed annual budgets determined largely on a cost-plus basis. Apart from an obvious lack of incentive for efficiency, this method of distributing funds resulted in major differences in funding levels across the country, with historic levels of over- or under-funding being perpetuated each year. Within the hospitals, management systems were cumbersome and accountability mechanisms weak. Accounting systems were very poorly developed, and consisted almost entirely of rather crude measures of patient throughput. Thus there was a lack of accountability to and control by ministers who in turn were accountable to taxpayers.

The passing of the Area Health Boards Act in 1983 paved the way for the amalgamation and restructuring of the 27 hospital boards and the district health offices of the Department of Health into 14 area health boards (AHBs). In the same year, the first population-based funding formula was introduced to reflect the health care needs of the different regions. To ensure continuity of service provision, a method was developed for moving the funding levels of AHBs gradually towards “equity” – i.e. the amount of funds that each AHB should have received according to the formula. However the process was slow and inequities in the regional allocation of funds persisted.

The restructuring of the 27 hospital boards into 14 AHBs was finally completed in 1988/89 and a revised version of the population-funding formula was introduced.² Funding for public health services was devolved to these boards but funding for primary health care and disability support services remained the responsibility of the Departments of Health and Social Welfare respectively. From 1990, in return for their share of government funds, each AHB was required to sign a 'contract' with the Minister which specified the range of services they planned to provide together with a set of performance indicators. The purpose of these contracts was to ensure that AHB activities were consistent with a national health charter and a set of goals and targets (Clark 1989), and to improve the general accountability of the boards. This did not mean that expenditure would be linked to a board's level of output: while the contracts did include some rather crude measures of particular outputs, most service outputs remained unspecified and unmonitored, and quality measures were absent. Instead, contracts were based on operating plans agreed with the Minister which were consistent with the boards' five-year strategic plans. Thus a key objective of this contracting process was to make explicit the planning, as opposed to the actual provision, of services. A board's performance was then measured against the agreed plan.

During this period, the Department of Health also contracted directly with a number of large NGOs such as the New Zealand Family Planning Association, the New Zealand Plunket Society and the Royal New Zealand Foundation for the Blind. These contracts were initially very loose and specified (in very broad terms) the relationship between the parties, a broad description of the services to be provided, the price to be paid and manner of payment, and reporting requirements to the funder. However by the end of the 1980s the Department of Health moved increasingly towards the linking of expenditure with outputs in these contracts in line with state sector reform generally. By 1991/92, both price and volume of services were negotiated with all independent service providers. Volumes were usually determined according to

² A revision of the formula was required for a number of reasons including the need to account for the wider range of services provided by area health boards compared with hospital boards; to reflect the focus of the boards on health promotion and prevention; to accommodate the devolution of responsibility for capital funding from the central government to the boards; and to incorporate appropriate incentives into payments for flows of patients across board boundaries.

historic trends rather than by any explicit decisions by the Department (renamed the Ministry of Health in 1993) to shift resources across services. While providers generally continued to carry the risk of over-provision, there was now some room for renegotiation during the term of the agreement if contracted volumes were exceeded. However, many providers could only provide very crude information about service outputs and much of the detail about the nature and quality of service was also not specified in the contracts.

In 1993, the so-called “health reforms” were introduced following widespread deregulation and reform of the economy more generally. The AHBs were abolished and separate organisations became responsible for purchasing and providing services (Upton 1991). The expectation was that splitting the roles of purchasing and provision would improve transparency and accountability, and encourage greater technical efficiency by requiring hospitals and other providers to compete for contracts from purchasers (Ashton et al. 2005). The split also finally enabled all funds for personal health and disability support services to be channelled through a single purse. This effectively meant that all (public and private) service providers, including primary health care providers, were required to contract with the Regional Health Authorities initially, and later, with the Health Funding Authority.

A full account of methods and trends in contracting practices over the 1993-1999 period has been reported elsewhere (Ashton et al. 2004). A somewhat legalistic and at times contentious contracting system was seen to impose high administration costs, exacerbated by multiple purchasers and short term contracts (Ashton 1998b; Ashton et al. 2004; Cumming & Salmond 1998; McLean & Ashton 2001). There were reported improvements in accountability, but little evidence of efficiency gains, at least within the Crown Health Enterprises (i.e. the state-owned providers) (Ashby 1996; Ashton et al. 2005; Deloitte Touche Tohmatsu 1996). It has also been argued that the competitive approach to purchasing increased fragmentation, led to more acrimonious relationships and undermined quality where attention focused on financial rather than clinical performance (Barnett et al. 2001).

In primary care the 1993 reforms brought considerable benefits, including opportunities for networks of general practitioners (GPs) to hold their own budgets for pharmaceuticals and laboratory tests, and an increase in the numbers of community-led primary care organisations (Malcolm 1997; Malcolm & Powell 1996; Malcolm et al. 1999). The purchaser/provider split also opened up opportunities for Māori providers to contract for the provision of services to Māori and encouraged funders to work with mainstream providers to improve cultural appropriateness, promote Māori programmes and facilitate the development of Māori providers (Ministry of Health 1997). By the same token, lack of consistent policy and personnel created instability and high infrastructure costs for Māori and other small providers (Cunningham & Durie 1999).

The NZPHDA model has brought a return to population-based funding for District Health Boards. Unlike the AHBs, the budget for DHBs now includes primary health services and disability support services for people aged 65 years and over, but currently excludes funding for public health services and disability support services for people below 65 years. With this budget, DHBs must either provide services directly via their provider arms, or contract for services with non-government service providers. Key issues for this research on the restructuring into the NZPHDA model include examining which, if any, of the above benefits from the previous model are retained, and whether problematic aspects of purchasing and contracting under the competitive model have been removed. An issue of particular concern is whether the re-integration of purchasing and provision in DHBs will lead to reduced opportunities for community providers, including Māori providers (Ministry of Health 2000).

3 Population-Based Funding

The funding of DHBs on a population-basis is in line with the general objective of encouraging a population focus in the health sector as outlined in the New Zealand Health Strategy (King, 2000). In order to calculate each DHB's share of funding, the Ministry of Health developed a formula which takes into account the size and demographic mix of a DHB's population; the average national cost of health services used by each demographic group; and the level of unmet need in the population. Additional adjustments are made for the degree of rurality of the district and for service use by overseas visitors (Ministry of Health. Population-Based Funding Website). Roll-out of funds based on the population-based funding formula (PBFF) was undertaken incrementally, starting in December 2003, with the full equitable allocation being reached in the 2005/06 financial year.

When the DHBs were first established, their funding allocations were based largely upon the funding flows that had been established under the previous model via price and volume contracts with the HFA. This meant that, from a population perspective, some boards were over-funded in comparison to their 'equitable' share whilst others were under-funded. Thus any move from funding via contracts to population-based funding would inevitably mean some reallocation of funds amongst the 21 DHBs. It also introduced the need for compensation from one board to another for any flows of patients across districts.

Prior to the introduction of funding via the formula there was considerable concern amongst our case study DHBs about perceived inequities in the construction of the formula, and about the quality of the data. For example, outdated population statistics were used for the initial formula, and the domicile information attached to National Health Index numbers was sometimes incorrect. Although AHBs had been funded through a population-based formula prior to 1993, for DHBs the formula needed to include funding for primary health care. The lack of good information about patterns of utilisation of primary health services meant that this added an extra dimension of uncertainty.

Some DHB respondents - particularly those from larger DHBs - also expressed concern that the formula developed by the Ministry does not take into account differences in the costs of service provision. Differences in costs can arise due to differences in levels of efficiency. However *unavoidable* differences in costs may also differ due to regional differences in salary levels, property values and other input costs, or to systematic differences in levels of acuity. Levels of acuity in turn may differ across districts because more complex cases are referred to DHBs which provide more specialised services, or because people with greater health service needs relocate to these more specialised DHBs.

Once the allocation of funds via the PBFF had commenced, concerns about perceived inequities in the formula seemed to diminish to some extent. As one respondent put it: “...*the formula’s accepted now as being the formula*”. Even so, the quality of some of the data remains poor and concerns remain about costs differences. If there are inherent differences across DHBs in the cost of service provision which are not compensated for by the formula, inequalities in access to services across DHBs and in health outcomes may be perpetuated.

In spite of these and other perceived weaknesses, the overall view of our respondents was that funding via the formula is likely to result in a more equitable allocation of funds than funding via contracts. The attention instead has now shifted towards inter-district payments for services provided to out-of-district patients.

3.1 Inter-District Flows

The existence of 21 DHBs means that there are numerous inter-district flows (IDFs) of patients, with most flows being from smaller DHBs to larger ones which provide a wider range of services. This introduces uncertainty and risk for all DHBs but especially for larger DHBs which are net claimants of IDFs and where payment for IDFs accounts for a high proportion of total revenue. This revenue will decline if referral patterns change or if other DHBs decide to provide the service themselves. This would effectively be a double blow for DHBs whose proportion of revenue received from IDFs is relatively high but whose revenue has already declined under

the PBFF. Some DHBs are managing this risk by working together on service planning and the impact of any changes on future flows of patients. For example, Auckland and Waitemata have collaborated on the repatriation of secondary medical and surgical services to the Waitemata region.

During the period of this research, the Ministry was undertaking an extensive work programme for improving information about the types and volumes of IDFs and developing more accurate payment processes. In the first year of the PBFF, the DHBs were effectively paid a lump sum for the estimated volume of services provided to out-of-district patients. In the second year, there was more flexibility, with DHBs having the ability to negotiate a ‘wash-up’ for inpatient flows based upon the actual volume of inpatient services provided. In the third year, this wash-up applied automatically to the inpatient services of all DHBs. The aim of the Ministry was first, to put into place appropriate systems and processes for collecting the necessary data, and then working with DHBs to develop mechanisms for improving the management of IDFs.

Notwithstanding this work programme, the DHBs reported a number of problems with payments for IDFs. Some of the national prices set by the Ministry do not reflect the actual cost of service provision and so DHBs may not be adequately reimbursed for some cases, especially the more expensive ones.³ It was also noted that payments for IDFs were often late, and sometimes had not been paid at all.

While considerable work has gone into improving the accuracy of inpatient flows, there is still insufficient information to enable wash-up adjustments to be made for IDFs in other categories of services. This means that DHBs with net inflows of these categories of patients have little incentive to provide the service to out-of-district patients once their agreed volumes have been reached. We heard anecdotes of patients who had been denied access to outpatient services in other DHBs, apparently for this reason. In an attempt to address this issue, the Operating Policy Framework 2005-2006 includes a guideline which states that, where there are payment disputes, the

³ National prices were reviewed in 2005 and now include Auckland DHB cost data. This may have alleviated these concerns to some extent.

DHB providing the service must continue to provide IDF services until the dispute is resolved. However this type of guideline will be difficult to monitor in circumstances where waiting for an outpatient appointment is the norm.

Another concern about IDFs is the high cost associated with tracking, categorising and analysing the flows. Much of this cost is borne by the DHBs which have a financial interest in securing accurate payment for the services that they or their contractors provide. The cost varies considerably across DHBs, depending upon the proportion of their budget that is associated with IDFs. However no funding is allocated to DHBs for this work.

IDFs - and their associated problems and costs - may decline over time as some DHBs extend their range of services. But by the same token, some specialties are becoming increasingly regionalised as developments in technology result in greater concentration of these services. IDFs may also increase if workforce pressures continue and some of the smaller DHBs are unable to retain or recruit appropriate specialist staff. A more accurate and up-to-date method of pricing services, together with timely reimbursement for IDFs, are essential if fairness in resource allocation across DHBs is to be achieved.

4 Devolution of Contracts to DHBs

The shift to purchasing by DHBs required the devolution to the 21 DHBs of existing contracts that had been negotiated by the HFA or the Ministry. The process of devolving contracts commenced from 1st July 2001, six months after the establishment of the DHBs. Contracts for personal health services and mental health were devolved in the first round, followed by the contracts for disability support services for those aged 65 year and over in October 2003. Both of these rounds were problematic, although a small number of CEOs reported that the process of hand-over in the second round had gone more smoothly.

Descriptions offered by respondents from DHBs about the process of contract devolution included ‘appalling’, ‘a disgrace’, and ‘an absolute mess’. Reported problems included:

- long delays in getting access to copies of some of the contracts
- inaccuracies in the contracts and a need to do “*a huge amount of checking*”
- a lack of information to allow DHBs to undertake due diligence
- a lack of information on historic patterns of service use and expenditure trends, especially in the case of older people
- the slowness of the process, in part due to the fact that there were delays in the process of changing from paper copies to scanned copies of the contracts
- a lack of capacity within DHBs to undertake the processes required for contract devolution
- the absence of any national training programme to prepare DHB personnel for the devolution process.

Of particular concern was the financial risk associated with some of the inaccuracies in the contracts. As one respondent reported:

“Every time we review a contract we find a stuff up.....We had to pick off those we were concerned about, we did two and we found 2.5 million bucks they [i.e. the contracted provider] shouldn’t have – and that was two of them”.

On the other hand, some contracts were under-funded. While a national risk pool had been set up to manage some of these risks, CEOs expressed uncertainty about the effectiveness of the risk pool in covering the size of the financial risk involved. It was suggested that greater discussion of risks should have occurred prior to devolution.

The general muddle in contracts was perceived by several respondents to have developed over a number of years as a result of poor management and a lack of due diligence throughout by RHAs, the HFA and the Ministry of Health. While the process of devolving contracts to DHBs was problematic, it did at least encourage the DHBs to check the detail of the contracts although this process was sometimes constrained by a lack of capacity. Some acknowledged that the Ministry had been helpful and worked hard to make contract transfer successful.

While some problems remain, we gained the clear impression that, as a general rule, providers prefer contracting with a local purchaser rather than with the HFA or the Ministry. In part this is because it is easier to identify the relevant person within a DHB whereas the Ministry was perceived as having a rapid turnover of staff. Another barrier previously was the ambiguity about where the contracts were located within the Ministry's systems and agencies. The following comment typifies the view of many non-government providers:

“I'm not saying everything runs really smoothly with the DHB ... we still can't always agree on things and we still do have to negotiate things, [but] I think just having people locally that you know if necessary you can just jump in the car and go and see them rather than jump in the plane and go to see them in Wellington ... administering a local contract just makes the relationships and the resolution of issues a lot easier.”

By the same token, we also got a clear sense that purchaser-provider relationships often remain uneven, with negotiations and systems being driven by the DHB rather than by working together in a partnership. As one NGO respondent commented with regard to the contracting process, *“it comes back to people”*, their skills, and their willingness to listen and to negotiate.

It must also be noted that not all respondents were in favour of *all* contracts for personal health services being devolved to DHBs. Some were of the opinion that for services where patients often receive care in another DHB, national contracts would be both more efficient and more equitable. This not only applies to tertiary and quaternary services which require highly specialised skills and/or equipment: it also includes some less specialised services (such as maternity services) where there can be a high volume of patients receiving care outside of their own district.

4.1 Devolution of Funds for Public Health and Disability Support Services

Opinions are very mixed about whether funding for public health services and disability support services for people aged less than 65 should also be devolved to DHBs. Many DHB respondents, especially CEOs, expressed the view that full devolution of funds was essential if they were to achieve a true population-based, locally-oriented approach to purchasing, especially with respect to supporting the development of PHOs. Others were more ambivalent, particularly about funding for public health services. Some considered that a regional approach might be more efficient and effective, while a few preferred the retention of public health funds by the Ministry.

Many public health and disability support services are provided by national organisations and so for these groups, devolution would mean negotiating and contracting with multiple agencies, rather than a single organisation (the Ministry). This is likely to increase costs and may fragment service provision. However, some NGOs reported that their experiences of contracting with the Ministry had not always been positive, with reference to uneven power relationships, inflexibility, and the Ministry being '*very unresponsive while demanding extreme responsiveness from community agencies.*' Some thought that the DHBs or their regional agencies might be more responsive and open to negotiation.

Separation of funding for social care (i.e. disability support) services from the funding for health services has often been identified in the international literature as a key factor which constrains integration of health and social care services (Glendinning 2003). Some countries (such as the UK) are therefore seeking ways of removing the barrier between health and social care by pooling the budgets for these services. In New Zealand, funding for health and disability support services had effectively been pooled since the mid-1990s. Thus the retention of funds for disability support services for those aged below 65 years by the Ministry effectively (re)-introduces the type of separation of responsibilities for the two types of services that other countries are seeking to remove. Retention of funds by the Ministry also seems contrary to the general purpose of the NZPHDA to establish organisational arrangements which encourage responsiveness to the needs of local communities.

By the same token, the devolution of funds for disability support services to the DHBs does not of itself guarantee either integration of services or community responsiveness (Glendinning 2003; Leutz 1999). It may also undermine potential efficiencies, especially in respect of contract administration. This applies both for the DHBs and for NGOs, many of whom contract with two or more DHBs. Three of the four regions have attempted to reduce the administration costs associated with contracting with NGOs by using the shared services agencies to manage their contracts. This role usually includes the provision of knowledge about the services provided by NGOs. It also sometimes includes monitoring of NGOs and the provision of audits, plus at least one of the shared services agencies plays a role in contract negotiation. There was, however, a unanimous view that DHBs should retain responsibility for managing the relationships with providers.

In some cases, devolution of funds to DHBs has exacerbated existing funding pressures (for example, in long term care for the elderly) because DHBs have less room than the Ministry to manage within their smaller budgets. There may also be some duplication of overhead costs in cases where a single contract has been split across two or more DHBs (Ministry of Health 2005b).

Overall, the case for further devolution of funds seems stronger in the case of disability support services than it is for public health services. However, according to Glendinning (2003, p.149): “The removal of structural barriers - whether these relate to organisational boundaries and responsibilities or to funding streams - is a necessary, but not a sufficient condition for integration” (Glendinning 2003). Improving service integration requires many other features including supportive national policies (for example, audit and performance management systems which span service providers); a willingness and ability of providers to collaborate across service boundaries; harmonisation of policies and procedures; and so on. These and other factors which have the potential to enhance service integration and community responsiveness need to be taken into consideration when weighing up the pros and cons of further devolution of funds from the Ministry to the DHBs.

5 Choice of Provider

A commonly voiced criticism of the NZPHDA model - especially amongst NGOs - has been that DHBs, being both purchasers *and* providers, have an incentive to favour their own provider arm over non-government providers when allocating contracts. On the other hand, some DHB interviewees pointed to the potential for a reallocation of resources *away* from DHBs if the primary health care strategy results in money being taken away from the secondary sector.

In the interests of clarity it is perhaps useful to consider these as two separate (though related) issues. The first - and perhaps most pertinent - issue relates to the question of whether the NZPHDA model incorporates any inherent bias towards public rather than private provision. Any such bias would be most readily apparent in situations where the same services are provided by both sectors so that public and private providers are competing for the same funding. The second issue concerns any shifts that occur over time because different types of services are provided by the two sectors.

5.1 Allocation of Funds Between Public and Private Providers

The question of whether the NZPHDA model incorporates any inherent bias towards provision of services by the public sector is, perhaps not surprisingly, viewed very differently by DHBs and NGOs. When questioned about the issue, our DHB respondents all stated quite clearly that they would not give preference to their own provider arm when making funding decisions. Rather, each decision would be assessed according to factors such as scope of service, safety, cost, and quality. There was also clear acknowledgement by some DHBs that part of the solution for reducing provider arm deficits was by developing primary care and public health interventions within the community. However, our observations at board and committee meetings revealed a more mixed message, with some conflicting opinions amongst committee members regarding the choice of provider.

While some members were clearly of the opinion that the provider arm should be treated as ‘just another provider’, others expressed the view that being a ‘good employer’ includes giving preference to the DHB provider arm in order to maintain employment levels.

During the period of our study, there were cases of contracts for services being shifted both into and out of the case study DHBs. In one particular instance, a DHB chose not to renew a contract with a private provider despite evidence presented by the provider that suggested that in-house provision by the DHB would be both more costly and inadequate in the longer term. A few months later the DHB found that their capacity was indeed inadequate as the provider had suggested. The DHB apologised and negotiated a new contract with the same provider. The decision-making process was more systematic and transparent the second time around.

From the perspective of NGOs, there was widespread concern that “*DHBs can never be neutral in the way that the HFA was*” and that they would therefore favour their own provider arm when allocating contracts. One umbrella social services organisation conveyed a great deal of ‘angst’ from their members about this issue, while another stated ultimately the issue would be challenged at the Commerce Commission. The following selection of opinions and comments made by respondents from NGOs give a flavour of their feelings about the issue.

- “*If you go around the country now there are a number of boards who have decided to preferentially fund their provider arm in a transitory way or in a supportive way and they have shown no similar regard to other providers whom they contract with.*”
- One (named) board reportedly said that all extra money received will go into their provider arm.
- One NGO perceived a “*worrying trend*” of DHBs capturing money for their own provider arms “*in order to get a margin to offset their bottom line*”, and that “*there are more and more examples of RFPs being put out there, clearly written so that only the provider arm can respond*”.

- A consumer advocacy organisation voiced concern that *“the relationship is still far too strong between the planning and funding arm and the provider arm of the district health boards”* and *“we’re not all on an even playing field at the moment”*.
- A Māori provider expressed the view that: *“...much of the Māori funding which ought to come to Māori, in my mind, is being taken up by a Māori health unit in the organisation”*.

In addition to these general concerns about the choice of provider, some NGO respondents also expressed concerns about perceived inequities of payments to public and private providers. For example, one noted that: *“DHBs will always award themselves a nice warm comfortable increase once a year to meet cost of living. They may award themselves 3%; if we’re lucky they might give the sector 1% as though it’s somehow cheaper out in the sector than it is in the DHB.”* Another suggested that: *“NGOs are expected to balance the books each year..... yet a DHB can live in debt... If the current provider of the service that they are contracting can’t balance the books, they get someone else”*

As one board chair noted, some of the concerns about inequities of prices are probably misplaced because, for hospital services at least, all contracts use a standard price/volume schedule based on national service frameworks. Some NGOs also indicated that they expected any inequities in the selection of providers to decline over time as DHBs become more competent and confident in purchasing and monitoring services, and become more familiar with the type and quality of services that private providers are able to offer. Even so the widespread perception that we found amongst NGOs of unfairness in the selection and treatment of private versus private providers is a matter of some concern. It suggests that some monitoring of purchasing decisions over time may be desirable.

Non-government providers would also find it useful if each DHB developed a policy that outlines how they plan to deal with private providers. For example, is an open-market approach likely to be followed when contracts come up for renewal, or is there likely to be an ongoing purchase of elective surgery or maternity services from the private sector? While some of this uncertainty has been ameliorated by a move towards longer term contracts, some non-government providers still reported difficulties in making investment decisions when future opportunities for access to public funding remain uncertain.

5.2 Allocation of Funds Across Services

In New Zealand, most secondary and tertiary services have traditionally been provided by the public sector while most primary health and disability support services have been provided by private organisations. Any changes in patient management that result in a shift across services will therefore also result in a shift of funds between public and private providers.

Over the past couple of decades there has been a worldwide trend away from institutional care towards care in the community. In New Zealand, there have also been national strategies to encourage deinstitutionalisation in the mental health sector and, more recently, greater emphasis on primary services via the primary health strategy. Because institutional care in New Zealand is provided predominantly by public sector organisations while community care is provided predominantly by NGOs and other private organisations, the trend has resulted in a significant shift of resources away from the public sector to privately owned organisations. Between 1980 and 2002, the percentage of public funds spent on institutional care declined steadily from 70% to 56%, while the percentage spent on community care increased from 21% to 36% (Ministry of Health Various years).

The development of PHOs provides an organisational structure which may further facilitate this shift of funds into the community setting. For example, one board decided to contract with a PHO for the provision of retinal screening rather than to continue providing this service in-house. The general expectation would therefore be for the shift of funds into community-based services to continue into the future, possibly at an accelerated rate.

A similar trend might be expected in the case of mental health services because, in these services, the growth in the workforce is expected to be in the support area (i.e. services supporting people in their homes, in accommodation and in employment) and these services are delivered predominantly by NGOs. However one national stakeholder noted that there is a view amongst NGOs that the proportion of mental health funding going to NGOs may have remained static - and may even have declined - over the past three years. Figures reported by the Ministry of Health show that the proportion of mental health funds going to NGOs did indeed remain static at 28% for the 3 years between 2001/02 and 2003/04, with the remaining 72% going to DHBs (Ministry of Health 2005a).

The choice between providing care in the hospital setting or in the community is by no means straight forward. As one CEO noted:

“We have never done anything in terms of the cost benefit of doing something in the community, some treatment in the community rather than doing it in the hospital. We all know inherently we’ve got to keep people out of hospital but we haven’t actually cracked how to get certain things done - follow ups to surgery for instance”.

In summary, while DHBs clearly have the intention of treating their provider arms as ‘just another provider’, in practice this may be hard to achieve. Potential barriers include:

- inadequate knowledge about the scope and quality of services that private sector providers are able to provide (*“They still see us as pretty low level support providers”*);
- perceived high level of risk (*“I guess there are some barriers in people’s mindsets. And it would take some courage in order for the provider to actually take a significant contract away from the DHB provider and put it up for tender in the NGO sector”*);
- additional transaction costs associated with finding and selecting appropriate providers, and with negotiating, writing, monitoring and enforcing contracts (Ashton 1998a);
- a desire to be loyal to employees in the DHB provider arm.

6 Contracting Issues

6.1 Style of Contracting

When the DHBs were first established, few had either the capacity or the capability in their planning and funding teams to undertake innovative and active purchasing. The fall-back position was therefore either to simply rollover existing contracts, or to follow what was referred to as the “*old style of contracting*” - “*for example, a 158 page contract prescribing a particular type of intervention model.*” However, even in these cases there were reportedly some small gains in flexibility which allowed smarter use of resources and better outcomes. Other DHBs, particularly some of the smaller ones, grasped the opportunity early on to apply local knowledge to resource allocation, leading them to a style of contracting that was more innovative, more dynamic and more outcome driven than had been the case under the HFA.

Over time, DHBs have developed the capacity and processes to be more proactive in their approach to purchasing. Some have commenced a systematic process of contract review, with each contract being assessed against a set of criteria. This is allowing some rationalisation of services to take place, with many contracts being terminated or renegotiated when they come up for review.

Over the period of our study, the general trend was towards more user friendly, less bureaucratic contracts, particularly in cases where the dollar amounts are relatively small. As one DHB respondent put it: “*It seems sensible for a larger contract to have a very full contract but others, letters of agreement or something that is more user friendly is something that we want to move to. Also they need to be much more outcome based.*” There has also been a trend towards longer term contracts, with annual contracts sometimes being replaced by three or even five year terms.

One other issue about the contracting process that was brought to our attention was the difficulties faced by DHBs when either the Ministry or another DHB has negotiated key aspects of service development and/or contracts with providers. This generally occurs in regional (i.e. lead DHB) contracts or contracts with national providers, but has also occurred in contracts with local providers, particularly Primary Health Organisations. DHBs are required to honour the resultant contracts and payments but relevant information about the negotiations is not always well-shared by the negotiating body. The result is that a DHB may be required to pay for a service which it considers to be low priority for its particular population, or at a price that it regards as too high. If service planning and development is to be consistent, it would seem essential that the organisation that is paying for services should at least be involved in any relevant discussions and negotiations.

6.2 Capital Expenditure

There is considerable concern amongst some NGOs that their contracts with DHBs do not include any allowance for capital expenditure or service development. Instead, the assumption seems to be that prices should be adequate to cover both operational and capital expenditure. NGOs from a number of sectors (especially Māori and Pacific providers and the disability sector) considered this to be problematic for a number of reasons.

A lack of funding ear-marked for capital expenditure may encourage some NGOs to draw down on their operating expenditure so that either the quantity or quality of services provided may be undermined. As one provider commented:

“So that’s how you do it. You basically take money from your contracts from your service delivery money and invest that into your capital expenditure and hope that you’ve got enough to do that, and some contracts you don’t, that’s the reality.”

The absence of any capital expenditure seems to indicate that NGOs should lease or rent capital items such as buildings, cars or equipment rather than purchase them outright. Yet this can be very risky from a business perspective. It may mean that the choice of providers is constrained if potential new providers cannot raise adequate capital to set up in business or are not willing to shoulder this risk. The lack of capital expenditure also means that NGOs must divert more time and attention away from direct service provision towards raising funds from other sources.

There is also a perception amongst NGOs that the lack of capital funding is inequitable, because, while DHBs receive capital funding from the Ministry, NGOs do not. This may exacerbate allocative efficiency if depreciation on DHB assets is automatically reinvested in the hospital sector:

“The twenty eight million depreciation investment always goes into hospitals of building bricks and mortar and whatever hospitals people would like. So you’re never shifting serious money on the investment side to support the primary strategy. You’re re-investing back in hospitals and the community side is strapped for capital cash development. So that’s a serious funding issue.”

The lack of ear-marked capital funding would not be a problem if the prices paid to NGOs were sufficient to cover both capital and operating expenditure. However if prices are low (as, for example, has historically been the case for long term care for the elderly), NGOs may simply not re-invest in capital (Ministry of Health 2005b). This undermines the quality of service in the short term and in the longer term may lead to supply shortages if providers can no longer remain viable. Low prices together with lack of investment capital are now encouraging providers of aged care to leave the sector. This is occurring at a time when investment in this sector should, arguably, be increasing if the needs of an ageing population are to be met in the near future.

6.3 Monitoring, Auditing and Reporting

Monitoring of contracts is viewed by DHBs as a key mechanism for minimising risk. The monitoring of contracts with providers locally by DHBs, rather than by the Ministry or the HFA, was generally seen as an improvement by both the DHBs and providers. However, in our first round of interviews, both DHBs and providers were encountering problems with the monitoring process. Several providers reported difficulties where the quality of information in their contracts was poor, related contracts were running out at different times, or providers were being monitored against contracts the DHB hadn't written. Some DHB respondents noted that their monitoring and audit procedures had picked up cases where providers had failed to deliver according to the contract but the problem had not previously been picked up by the Ministry or the HFA. Consequently some DHB staff were rather scathing about the performance of SSSG and the HFA in their monitoring efforts.

As contracts were renewed, DHB portfolio managers were able to negotiate desired changes, including changes in clauses relating to monitoring and reporting. Many DHBs tried to develop more appropriate and meaningful performance measures than those that existed in the earlier contracts. This often involved the development of more comprehensive databases and clearer reporting requirements, both of which were generally welcomed by providers. However, some providers expressed dissatisfaction that, in spite of improvements, monitoring processes often still do not capture all relevant aspects of service delivery. For example, a provider of disability support services noted that their funding was based only on volumes of face-to-face contacts, but occupational therapists, for example, deliver two thirds of their work indirectly and this is neither funded nor captured in the monitoring data.

6.4 The Roles of Shared Services Agencies and HealthPac

Some contracts (most notably community laboratories and pharmacies) are managed by a shared services agency (SSA) on behalf of the DHBs. The roles of the SSAs with respect to contracts vary from region to region but sometimes involve the negotiation of contracts with service providers as well as the drawing up and general management of the contract. While the use of an SSA for managing contracts makes economic sense (because it reduces transaction costs), some non-government providers told us that they have found the structure rather complex, with the lines of accountability becoming blurred with the additional layers of bureaucracy.

HealthPac is a government agency which acts as an agent for the DHBs in processing claims for subsidies (particularly for GP consultations, pharmaceuticals and laboratory tests), payments for contracts, and in managing and co-ordinating contracts. Our research suggested that this process has not always been running smoothly.

As one respondent noted, HealthPac needs to have “accurate and complete” information from DHBs in order to complete the contracting process. However this information is not always provided. Contracts are then to be turned around within five working days. In some cases the contracting process is complex (particularly the national contracts covering large numbers of providers), and DHBs themselves are not always able to achieve deadlines to finalise negotiations on contracts. One NGO informant described contracts being reworded by HealthPac without understanding what the contract was supposed to represent. In another case, two separate contracts were returned from HealthPac merged together. One organisation reported that they had now settled on crossing out the bits in the contract that are incorrect, initialling the changes and then presenting the contract like that to the negotiating partner. This informant observed the DHBs to be accepting of this ‘solution’ because of their own frustrations with HealthPac’s role.

These difficulties with contracts and payments have caused tensions between the DHBs and HealthPac. Unlike the SSAs (which, being owned by and accountable to the DHBs of their region have a close relationship with the DHBs), we gained the impression that there is generally little direct contact between DHBs and HealthPac.⁴ Moreover, as one respondent put it: “There’s no relationship management processes between HealthPac and the DHBs”.

These problems are likely to diminish over time as HealthPac, the DHBs and the SSAs work together to develop solutions. However the system involves multiple agencies and funding streams, and so appears rather cumbersome and bureaucratic. The use of a third party - particularly in contract negotiations - may also hinder the development of constructive purchaser-provider relationships.

⁴ In the northern region, the Northern DHB Support Agency maintains the relationship with HealthPac on behalf of the DHBs.

7 Financial Management by DHBs

Under the NZPHDA (s.10) the Crown funds the DHBs to provide, or arrange for the provision of, agreed and specified services. Under the Act, the DHBs are responsible to the Minister, according to the Public Finance Act 1989 (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 financial viability, to cover all its annual costs from net annual income, to act as a successful going concern, and to prudently manage its assets and liabilities. Funds are allocated to the DHBs for three functions: the provision of services (via the provider arm); the purchase of services (via the funder arm); and for governance and administration. DHBs are then required to provide information to the Minister and Ministry that allows their performance to be monitored against their District Annual Plan (DAP) and Crown Funding Agreement.

There was clear understanding amongst the participants in our research that the government expects DHBs to live within their budgets and that the Minister would accept “*no excuses for over-spending*”. However some DHB respondents considered the Minister’s expectations to be unrealistic, given the level of funding and the fact that many of the cost pressures (such as the cost of pharmaceuticals, blood products and equipment) are out of a DHB’s control. Any DHB that was initially in deficit was required to work with the Ministry to develop their DAPs towards breaking-even at the end of three years. Those with significant deficits (including two of our five case study DHBs) were placed under “Performance Watch” by the Ministry and so were monitored more closely than other DHBs. High performing DHBs are entitled to greater autonomy, and may receive their funding at the beginning of each quarter rather than at the end. Even so, we gained the impression that DHBs perceived this approach to the need to cut their deficits as punitive rather than supportive, with the main penalty being closer surveillance by the Ministry and concomitant reduced autonomy for the DHBs.⁵

⁵ This general approach is similar to that taken by the Department of Health in the UK for National Health Service (NHS) hospitals. However the focus there seems to be more on the principle of “Earned Autonomy” than on penalties for under-performance. [Department of Health. 2000. *The NHS plan: a plan for investment, a plan for reform*. London: Department of Health] A study into the effectiveness of these types of incentives found that the promise of greater autonomy served as poor incentives to drive performance because most managers believed that the freedoms and rewards promised under

For our case study DHBs, the aim of covering all annual costs from net annual income proved to be something of a challenge. All five of the DHBs had inherited some debt when they were first established and, by the end of June 2002, all five boards also recorded annual deficits ranging in size from around \$2m to over \$80m. In December 2001, the Ministry announced a three-year guaranteed funding stream. This provided an important degree of certainty and assisted the boards to develop strategies for the removal of their deficits over the period when funding was guaranteed. The move to population-based funding also assisted some DHBs to reduce their deficits.

By the end of the 2004 financial year, the financial performance had improved markedly in four out of five of our case study boards, as with other DHBs (Table 1). While the fifth still had a deficit at the end of June 2004, it too reported a small surplus by the end of June 2005. Ironically, the improvement in financial position created new problems for some board members, in part because the speed of the improvement meant that the board had not had time to adjust to the possibility of being able to expand services. One noted that there was still of legacy of deficit-dominated thinking. Another suggested that “the only risk we’ve got financially is in terms of whether or not we can spend the money!”

Table 1: DHB financial performance for years ended June 30

	2002	2003	2004
Auckland	-\$67m	-\$49.7m	-\$44.7m
Bay of Plenty	-\$3.4m	-\$6,5m	\$8.4m
Canterbury	-\$21.m	-\$10.4m	-\$1.2m
Capital & Coast	-\$83m	-\$0.5m	\$0.01m
Counties Manukau			
Hawke's Bay	-\$8.1m	-\$6.5m	\$0.2m
Hutt Valley	-\$2m	\$0.6m	\$0.2m
Lakes	-\$7.2m	-\$647.00	\$3.6m
MidCentral	-\$11.4.m	-\$6.7m	\$4.0m
Nelson Marlborough	-\$1.8m	-\$1.3m	-\$1,4m
Northland		-\$5.2m	\$0.4m
Otago	-\$10.3m	-\$11m	-\$9.6m
South Canterbury	\$0.7m	\$0.003m	\$3.5m
Southland	-\$5.6m	-\$6.4m	\$1.0m
Tairāwhiti	-\$2.1m	-\$0.9m	-\$0.01m
Taranaki	-\$9.3m	-\$5.7m	\$4.4m
Waikato	-\$4m	\$0.2m	\$173.00
Wairarapa		-\$0.7m	-\$5.7m
Waitemata	-\$16.9m	-\$16m	-\$15.4m
West Coast	-\$5.2m	-\$2.4m	-\$0.4m
Whanganui	-\$2.6m	-\$4m	-\$2.3m

Source: DHB Annual reports

The need to reduce deficits tended to dominate DHB decision-making in the early years and to pervade thinking at all levels of the organisation. As one interviewee very aptly put it: *“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.”* The existence of deficits tended to constrain innovation and to focus attention on short term solutions rather than on long term planning. In some cases, potential strategies for achieving long term efficiencies (for example, the development of nurse practitioner positions) could not be pursued because the DHBs were unable to allocate the additional resources required for such innovations in the short term.

The majority of the deficits were incurred in the provider arm, rather than the funder arm. Strategies for reducing the deficit initially revolved primarily around improving efficiency (especially through controls over staffing and in relation to corporate functions), achieving discounts on consumable items, and deferring expenditure on maintenance. However over time, the focus shifted towards a longer term view of financial management. CEOs commented on the need to understand better the nature of demand for services, to engage clinicians in improving the management of resources within their services, and to focus more on the role of primary care in the quest for achieving financial stability.

Options for reducing spending in the provider arm were constrained by the Minister's requirement for them to retain, as far as possible, the same level and quality of services. As one respondent put it: *"I think there are some really unrealistic expectations on the sector, always wanting a gold star standard..... There's not enough money to really do that adequately"*. Some boards reported that the Ministry had been helpful in working with them to find solutions to their deficit problem. However others had problems in achieving Ministry approval for the rationalisation of facilities and services.

Some DHBs were also exposed to the politicisation of decisions which limited their ability to rationalise their services. For example, in 2002, a decision by Northland DHB to suspend temporarily weekend and after-hours surgery at Kaitaia Hospital because staff shortages were threatening patient safety was reportedly met by *"a wide spectrum of local and national government politicians [who] wanted to have their say on the matter"* (INL Newspapers 2002). A loud public outcry, together with the involvement of the Minister in talks between the DHB and local interest groups, eventually resulted in the decision being reversed. This proved costly for the board, which, in spite of offering almost \$11,000 per week each to secure the services of two anaesthetist locums, ended up having to send an anaesthetist from the base hospital in Whangarei to Kaitaia. This in turn resulted in some surgical procedures at Whangarei hospital being cancelled.

The constraints placed on DHB decisions by the Minister reflect a fundamental tension that is common to many tax-funded health systems (such as the UK) in which responsibility for financing resides with the centre while responsibility for spending the funds is decentralised to local authorities. Ashton et al.. (2005) have suggested that such arrangements inevitably mean the constant reassertion of upwards accountability towards the body that is responsible for raising the money (Ashton et al. 2005).⁶ In such an environment, the development of good working relationships between DHBs and Ministry personnel is essential if short term crises are to be avoided and financial sustainability is to be achieved in ways that are acceptable to both parties.

⁶ One means of overcoming these tensions is to decentralise responsibility for financing to the local agencies that are responsible for spending the funds. This approach has been followed in Sweden and Denmark, where the counties and municipalities both fund and provide health services. However, devolution of the financing function increases the costs of revenue collection and requires considerable reallocation of funds to address regional inequities. Denmark is currently moving towards greater centralisation of the financing function.

8 An Assessment

The broad picture that emerges from this report is that the move to local purchasing and contracting by DHBs under the NZPHDA model is generally regarded as preferable to centralised purchasing because it allows greater responsiveness to local needs and preferences. Purchaser/provider relationships have become closer with local purchasing, and, hopefully, therefore more constructive. However an imbalance of power between the purchasers (i.e. the DHBs) and non-government providers is still very apparent. This imbalance is regarded as especially problematic by some Māori respondents who felt that “*When restructuring happened to DHBs, it felt like returning to the old CHEs - power and control was centralised to a mainstream health organisation again.*”

While there were initially some fairly major problems associated with the transfer of contracts from the Ministry to DHBs, this stimulated DHBs to examine the contracts in some detail. Many discrepancies were identified and in some cases, significant savings were made. Monitoring and audit of contracts is improving and purchasing decisions are becoming more transparent as DHBs have begun to document their decision-making processes more systematically.

Are funds being allocated fairly across DHBs?

Funding via a population based funding formula is clearly perceived to be more equitable across districts than the previous system of price and volume contracting. However, concerns remain about inequities in funding due to (a) differences in the cost of providing services across the DHBs, and (b) deficiencies in payments for inter-district flows, primarily due to information about flows of patient for non-inpatient services.

Is the system refocusing away from costs and more on outputs and outcomes?

One of the aims of NZPHDA model was to encourage a move away from the cost-driven environment that was perceived to prevail under the HFA. The fact that DHB decision-making was initially dominated by the need to reduce their deficits meant that cost remained one - if not *the* - major driving factor. How it is probably fair to say that the general improvement in the financial position of many DHBs over time, together with the development of more systematic and balanced methods of setting purchasing priorities, have resulted in more balanced decision-making processes which take a wider range of factors into account.

Are the methods of resource allocation contributing towards reducing health disparities?

The aim of encouraging DHBs to focus on the population living within their district may have the unintended effect of reducing the priority that a DHB places on services provided to out-of-board patients. This may create inequities in access for out-of-district patients, particularly where the DHB that is providing the service has funding constraints and where that service is not automatically compensated for any inter-district flows over and above some pre-negotiated volume of service.

Disparities may also be perpetuated if some DHBs have *unavoidable* higher costs and consequently are unable to provide the same level of service as other DHBs.

How have the reforms affected opportunities for non-government providers?

Because the purchaser/provider split remains in place for all services provided by non-government providers, in theory at least, the new model should not reduce – and may increase - the opportunities that are available to non-government providers (including Māori and Pacific providers) to develop services that best fit the needs of the local community. However Section 6 above suggests that, because DHBs are both purchasers *and* providers, they may not be as neutral in their purchasing decisions as the HFA, or even as they themselves might like (and claim) to be. Instead, a common perception amongst non-government providers is that DHBs sometimes have a tendency to favour their own provider arm. This suggests that some central monitoring of purchasing patterns may be desirable.

Has competition for funds been reduced?

The aim of avoiding “routine contestability for public funding for hospital services” (New Zealand Labour Party 1999) has generally been achieved, with a decline in inter-DHB competition, and an increase in inter-DHB collaboration. This is particularly apparent in the Auckland region where the three DHBs are working together more closely in planning and purchasing services. However, the need for inter-district reimbursements for treatments provided to out-of-board patients has encouraged some DHBs to review the scope of their services so that patients can be treated within its own district wherever possible. Thus for some services, competition for contracts has been replaced by competition for patient referrals.

There is also still real competition for funds both between public and private providers (i.e. DHBs and NGOs), and among NGOs. This competitive environment has no doubt been exacerbated by the large initial deficits of many DHBs and the consequent need to reduce, rather than increase, spending. It may also have been affected by the fact that the intentions of DHBs with respect to purchasing services from the private sector in the longer term is not always clear.

Are longer-term funding arrangements being made with organisations that perform well?

The development of a three-year funding stream has allowed the DHBs to plan further in advance and to negotiate longer-term contractual arrangements with many providers. However, part of the role of the DHBs is to review continually the question of whether they should 'make or buy' services. This means that the threat of non-renewal (and sometimes termination) of a contract remains for many service providers, including some of those who have a history of providing quality services.

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