Public Hospital Governance in the Asia-Pacific Region: New Zealand DHB Case Study

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Project background

- Purpose: “to increase understanding of how policy reforms are affecting the governance and performance of publicly-owned hospitals in selected countries”

Objectives

- To describe the policy context, recent policy developments and reforms in regard to public hospital governance and performance.
- To contribute to comparative analyses across different country settings, of publicly-owned hospital governance and performance

Case study research questions

1. What and how are policies affecting governance of publicly-owned hospitals, and what recent reforms have been undertaken?
2. What and how do different internal factors, including organisational capacities (technical and managerial), contribute to quality and efficiency?
3. What and how do external factors interact with hospital governance and clinical care?
4. How is hospital performance measured (internally and relative to other hospitals) and how is this information used by policy makers, hospital managers and the public?
5. Are there indications of relative performance linked to points 1-3?

Structure of report

- Context, broader health system structure and recent developments
- 5 DHB descriptions: BOP, Counties, Hawke's Bay, Hutt, Southern (focus on commonalities and differences)
- Performance measurement (national and local)

Methods

- Literature search including official publications
- Website search
- Interviews with key representatives from each of the 5 DHBs

COUNTRY CONTEXT, HEALTH SYSTEM STRUCTURE & RECENT DEVELOPMENTS

Country context

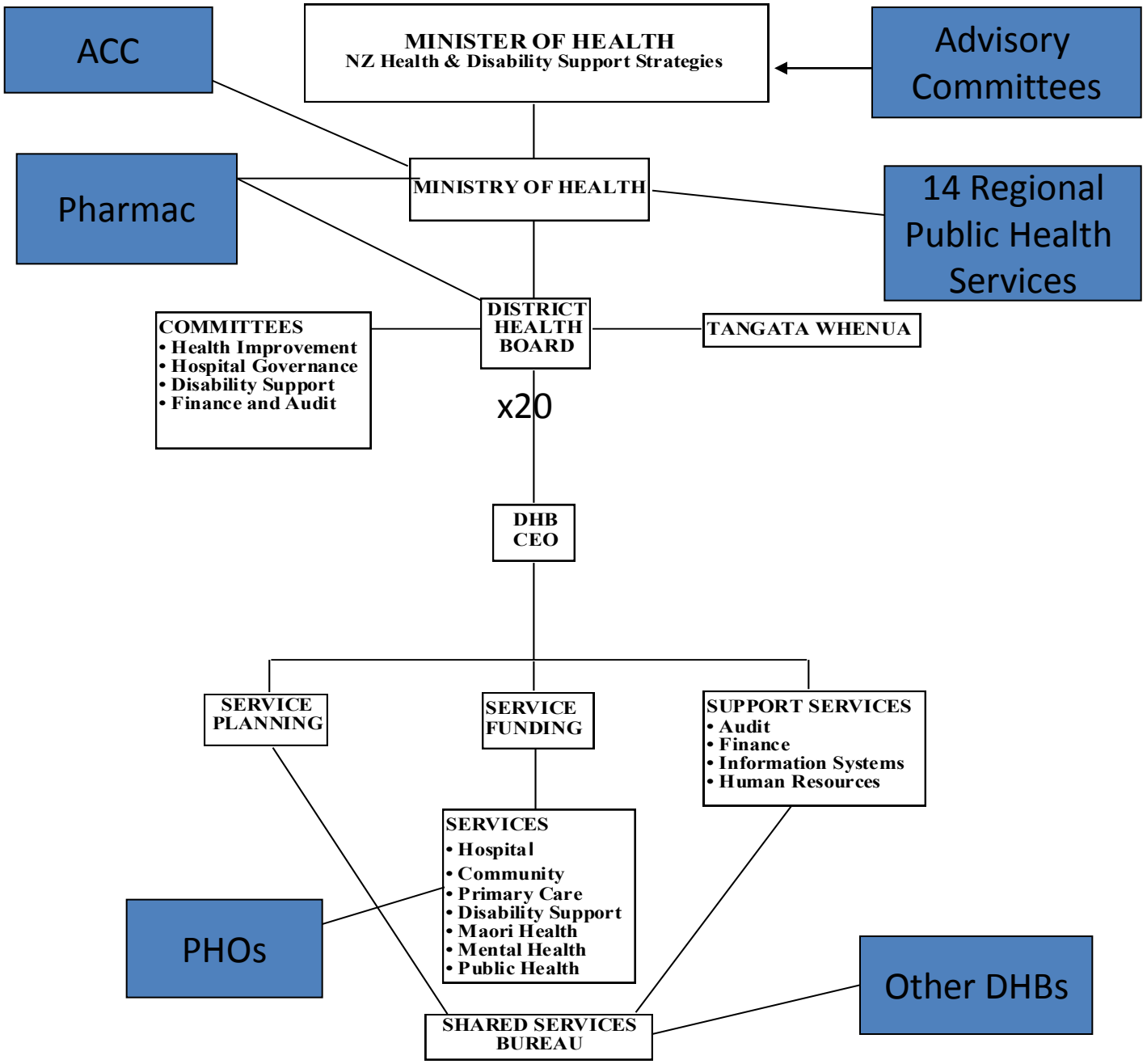
- ‘Mid-range’ economy; financial challenges
- Dispersed population; access variations
- Inequality in life expectancy, morbidity
- Health care funding one of multiple government priorities
- Total health exp above OECD average (10.2 vs 9.3% GDP)
- Govt portion of total exp increasing (~83%)

Health system

- Founded in 1938 Social Security Act
- Compromises between medical profession and govt led to today's institutional arrangements
- Mixed public-private delivery; dual practice
  - National Health Service model; single payer; 'two-tiered' public-private mix
- Public hospitals free; fees for primary care
- No private emergency clinics or trauma care; private hospitals delivery mainly electives
- Tax-based public funding approx 80% of total (Accident Compensation Corporation 7.5%)
  - 77% personal health; 18% disability support; 2% public health
- Compartmentalised health system with differing incentives for different providers
- History of regionalisation and democratic governance (only country with elected governance model)
- Considerable restructuring since 1980s

Public hospital governance

- Should be considered in broader context of District Health Boards (DHBs)
- Hospitals part of DHB provider arm and local health system; no real funder-provider split
- Tend to feature an Executive Leadership Team and Chief Operating Officer
- Governed by Hospital Advisory Committee and, in turn, DHB Board
- DHBs feature elected members but are firstly accountable for implementing govt policy
- Receive fixed funding based on PBFF and other allocations
- Various levels of sanction spelled out in legislation ensure DHBs focus on specific goals and performance requirements
- DHB CEO accountable to Board


ACC
MINISTER OF HEALTH
NZ Health & Disability Support Strategies
Advisory Committees
Pharmac
MINISTRY OF HEALTH
14 Regional Public Health Services
COMMITTEES
• Health Improvement
• Hospital Governance
• Disability Support
• Finance and Audit
DISTRICT HEALTH BOARD
TANGATA WHENUA
x20
DHB CEO
SERVICE PLANNING
SERVICE FUNDING
SUPPORT SERVICES
• Audit
• Finance
• Information Systems
• Human Resources
SERVICES
• Hospital
• Community
• Primary Care
• Disability Support
• Maori Health
• Mental Health
• Public Health
PHOs
SHARED SERVICES BUREAU
Other DHBs

- The DHB and hospital governance context is complex
- Several lines of vertical accountability
  - Hospital to DHB to multiple government agencies
- Increasing horizontal accountability
  - Regionalisation; integration; Alliance Leadership Teams
- Questions of coordination and transactions costs

Key organizations in New Zealand's health system (2013) (not including private hospitals or specialists)

National level:
Pre-2008 and ongoing:
* Ministry of Health
* Pharmac
* National Health Committee
New since 2008:
* National Health Board (a business unit of the Ministry of Health)
* IT Health Board
* Health Workforce New Zealand
* Health Quality and Safety Commission
* Health Benefits Limited
* Health Promotion Agency (since 2012)
Local level:
* 20 District Health Boards with associated public hospitals
* 32 Primary Health Organisations
* 12 regional Public Health Units
* Other contracted health and disability support service providers
New since 2008:
* 9 pilot Integrated Family Health Centres
* Alliance Leadership Teams in each DHB (since 2013)

This means

- Mix of plans and policies that DHBs must respond to
- Response brought together in Annual Plan
  - Each DHB plan is unique, but has common features
  - High-level of govt oversight of process
  - DHB must show logic behind plan, outline priorities and initiatives to achieve these
  - Key accountability document, along with Targets, Minister's annual letter, etc

In sum, DHBs have

- Reasonable autonomy in terms of how they seek to deliver on govt goals
- Considerable central oversight, especially when delivering on key goals (e.g. financial, Health Targets, electives) is in question

5 DHB CASES

Table 1: Five DHBs' Descriptive Information

DHB	Population	Area (km^2)	Geography	Budget $million (2012/13)	Staff (2012/13)
Counties Manukau	501,000	552	Urban	1.300	6200
Bay of Plenty	214,200	9,700	Mixed urban/rural	622	3000
Hawke's Bay	155,000	14,164	Mixed urban/rural	436	2500
Hutt Valley	140,000	916	Urban	420	2200
Southern	305,000	62,000	Mixed urban/rural	844	4500

Sources: DHB websites (accessed Jul-Oct 2013)

Some key themes

- Five DHBs, five different experiences
- Considerable number of centrally-driven areas of compliance (driven by reporting requirements) and expected activity coming from the various agencies;
- Almost endless flow of documents and information coming from central agencies;
- Some of this information given limited attention, as DHBs were often undertaking the activities listed;
- Some central agencies and their work more highly regarded than others;
- Central agencies sometimes showed a lack of leadership around issues facing DHBs, meaning DHBs had to create their own responses. Examples included the regionalisation process, health workforce planning, development of Alliance Leadership Teams, and topics such as water floridation.

Commonalities

- Use of Triple Aim to guide strategy and planning (note Southern's four-fold aim)
- Clinical leadership/governance in place, with management-clinical partnership
  - Different internal structures for this (e.g. HV has 'diamond' structure; BOP, Southern 'triumvirate')
  - Differing clinical board/council structures and powers
- Focus on integration with primary care, promoting community health, and reducing hospital pressure
- Where more than one hospital, DHB has 'one service' philosophy
- Ongoing internal reconfiguration (e.g. HV, Cap Coast, Wairarapa; Southern; Counties; HB)

Differences

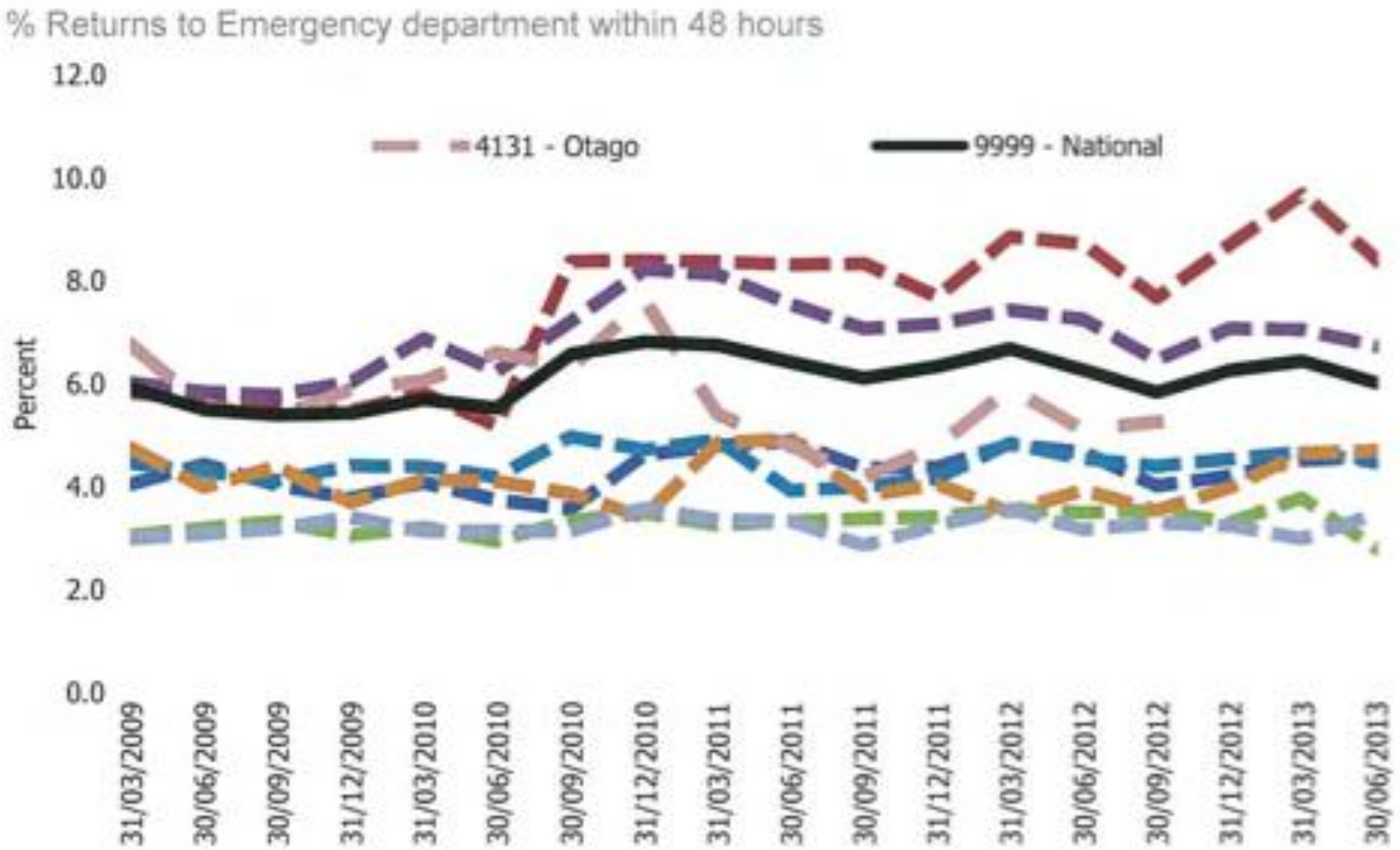
- DHB vision and missions
- How Alliancing is approached; and regionalisation activities
- How quality improvement is tackled
- How performance is measured

PERFORMANCE MEASUREMENT

Central govt measurement

- Health Targets
- MOH Annual Report
- ESPIs (elective services performance indicators)
- Hospital Benchmark Reports (until 2010)

- Various routine data difficult to access and require collating e.g. Basic indicators:
  - a. Infrastructure: hospital bed/population ratios, staff/population ratio; doctor/nurse ratio, doctor/nurse bed ratio;
  - b. Equity in utilisation: outpatient and inpatient by wealth / income/expenditure quintiles;
  - c. Throughput: outpatient visits and discharges per FTE doctors / nurses
- Some unavailable: Health Roundtable; DHBSS Hospital Performance and Productivity (some DHBs report components of the latter in Board papers)



Source: Hospital Quality and Productivity. Interim report to June 2013 (Southern DHB HAC papers)

HQSC measurement

- Quality and Safety Indicators
- Serious and Sentinel Event report
- Quality and Safety Markers
- Atlas of Variation
- Quality Accounts
- Consumer Engagement – patient-surveys

DHB-level measurement

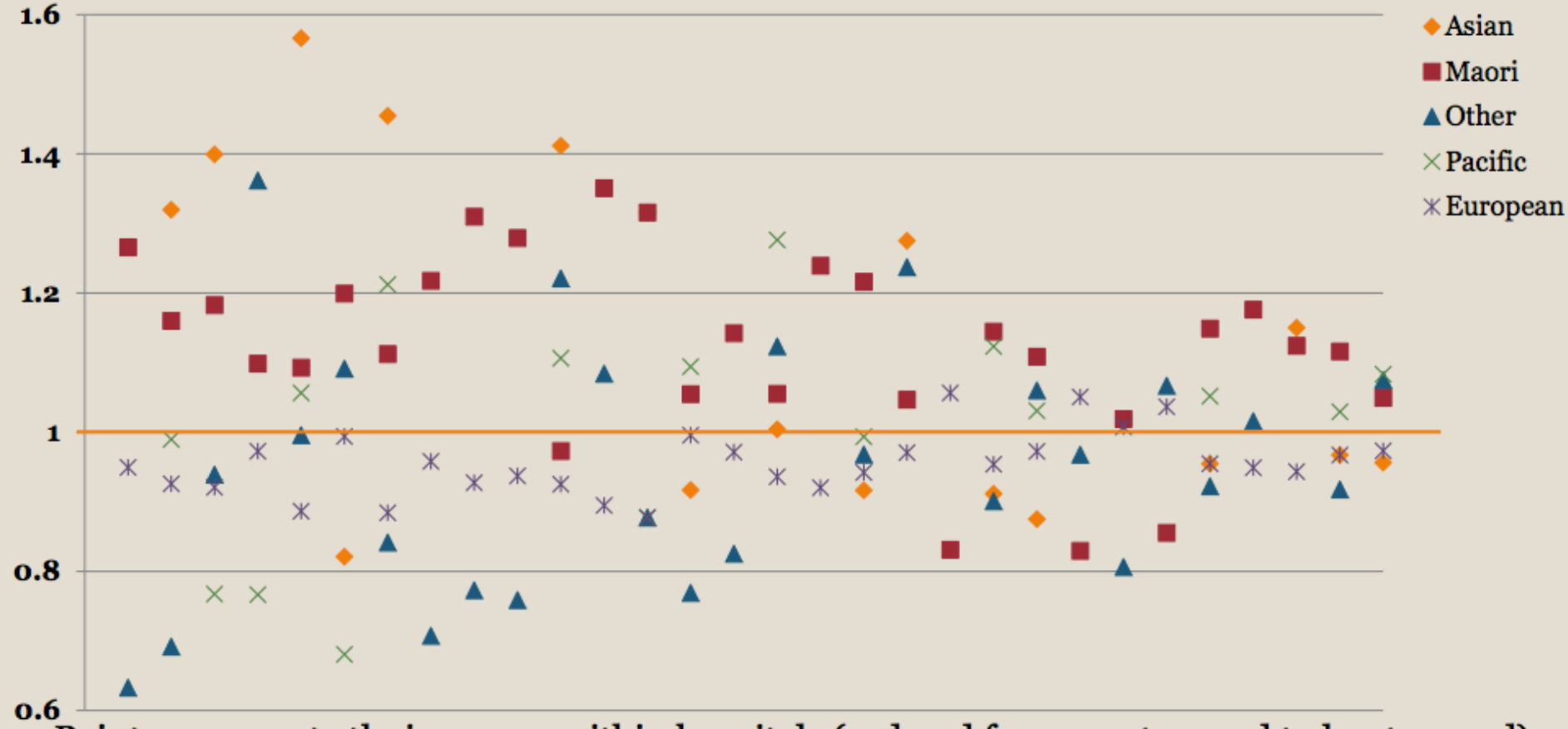
- Tends to be DHB-specific
- Balanced Scorecards; System-Level measures
- Annual Plan reporting
- Financial reporting
- Indicators of DHB performance

Other measurement initiatives

- ‘Public Hospital Performance Project’ (NMDS): Peter Davis et al
- Health system scorecard (routine data): Gauld et al
- Integrated Performance and Incentive Framework

Effectiveness

3. 30-day post-admission mortality by ethnicity



Points represent ethnic groups within hospitals (ordered from most spread to least spread)

Profiles – good performing hospital

	Overall rate (rank)	Equity: max/min (rank)
RSI (where 'average' hosp = 1)	0.96 (10)	1.02 (2)
day stay surgery (per 100)	61 (2)	1.01 (1)
PSI – post operative (per 100)	1.48 (1)	--
Unplanned readmissions (per 100)	9.05 (7)	1.59 (10)
30 day mortality (per 100)	1.64 (2)	1.50 (18)

Concluding thoughts

- Health system and hospital governance in NZ combines elements of historical development and recent policy
  - Makes for complexity, but permits local flexibility and innovation
- Strengths:
  - Emphasis on building semi-autonomous local health systems
  - Whole of system focus
  - Potential for innovation
- Challenges:
  - Complexity coordinating multiple central agencies and local systems: DHBs, PHOs, other providers
  - Performance measurement: how do we know what good performance is? How do we measure integration, innovation, leadership, governance, organisational culture, Alliances, etc?
  - How to use the 300+ health data sets in NZ?

FEEDBACK MOST WELCOME!!!