

# UNSHACKLING THE HOSPITALS

Report of the Hospital and  
Related Services Taskforce

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Hospital and Related Services Taskforce  
Wellington  
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## LETTER OF TRANSMITTAL

The Hon. David Caygill  
Minister of Health  
and  
The Hon. Roger Douglas  
Minister of Finance

We have much pleasure in presenting our review of hospital and related services. During the course of the last 12 months we have considered a number of options for the reorganisation of the public hospital system. Each of these was evaluated against the criteria of efficiency and equity. In the end we chose to recommend a fundamental restructuring of the way in which our hospital services are paid for and managed. Although we believe these changes essential, we do not regard them as ultimate ends. Rather, we consider our recommendations are a necessary step to achieve immediate improvements in the efficient and equitable use of government funds allocated to hospital and related services. They would enable the further evolution of the health system.

We believe the recommendations in our report are an answer to some of the long standing problems which beset the hospital system and those who work within it.

*Dorothy R. Fraser.*

Dorothy Fraser

*P. J. Scott*

John Scott

*A. S. Gibbs*

Alan Gibbs  
(Chairman)

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In addition to all those organisations and individuals who supplied written submissions or held meetings with the Taskforce (as listed in Appendix 4) we wish to thank the many other people who shared their knowledge and opinions on the health service with the group.

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# CHAPTER 1

## INTRODUCTION

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Over the last 12 months the Taskforce has conducted a wide ranging review of the New Zealand hospital system and international developments in health economics and the management of health systems. We had access to a considerable amount of recent research carried out for a number of reviews. The Taskforce chose to build on the useful work of the Health Benefits Review, analysing and developing the options set out there. We have tried to avoid duplicating the work of the review team or repeating the material covered in their report. We were also requested by the Minister of Health not to undertake, for a second time, all the consultative work done by the Health Benefits Review.

While we are mindful of the major part primary care plays in the health service, we have concentrated, as instructed, on the secondary sector—hospitals and their related services. Since the Health Benefits Review dealt mainly with primary health care, we consulted many groups in the secondary sector and received submissions from many others (refer to Appendix 4). In addition, we employed a number of overseas consultants to bring us up to date with developments in other countries.

Our staff included senior officers from the Department of Health and The Treasury. The consultants, Alan Gibbs (chairman), Dame Dorothy Fraser and Sir John Scott, provided part time input over the course of a year.

### 1.1 SOCIAL AND HISTORICAL PERSPECTIVE

In arriving at our recommendations we have given substantial consideration to the social and historical ethos of the New Zealand health system. As a result of political and social developments from the 19th century onwards, and in particular the landmark policies of the 1930s and 1940s, this system has become inextricably intertwined with 'the New Zealand way of life' in the minds of many people. Most New Zealanders have come to believe that a wide range of health services will be available, as of right, when they want them. In reality the system falls well short of this.

Over the years the health service has been shaped by a variety of factors. Health policy has accepted the need, sometimes consciously and at other times tacitly, to plan the service to cope with fluctuating demands caused by health maintenance, disease and accident problems, which arise unpredictably and intermittently.

The belief that from the 1950s to the mid 1960s this country had an outstanding health service by world standards is based on more than nostalgia. There was a good relationship between providers (the organisations and institutions that supply health care), government and other agencies, and the people served by the system. A generally constructive atmosphere prevailed. Since then we have had to come to terms with a radical alteration in the country's relative resources compared to other nations' as our economic growth stagnated.

Tensions developed rapidly. Successive governments felt constrained to limit the burgeoning expenditure on health. Providers of the services found themselves less capable of keeping pace with technological and other developments which characterise the most

advanced nations. This latter issue alone has been a central part of the debates on the future planning and management of our health services. Other strains developed as various groups of health professionals have striven for changed economic status or sought to retain their previous economic and administrative positions.

There have been significant alterations in social structures. Patterns of urbanisation, increased mobility, smaller families and the growing number of households where both parents work have broken the once traditional networks which cared for the elderly and disabled. The degree to which this dislocation has increased the demands now made of the health system was never envisaged by those who planned it in the 1930s and 1940s. Many other measures which seemed appropriate for that time have become unsuitable for the specific preferences of Maori, Pacific Island and other people in society.

There has been a growing recognition from the 1970s onwards, that free health care without queuing is impossible. Governments cannot do everything for everyone. All the technological possibilities of modern medicine cannot be made available; for instance, the latest applications of complicated vascular surgery, the higher flights of cosmetic and prosthetic surgery, and evolving medical techniques which are highly successful but benefit only a few people. Nor can people avoid responsibility for their own health in the expectation that outside agencies will protect them or repair the effects of their neglect.

The danger with our present system is that the articulate and vocal, with their own perceptions of their disadvantages, may persuade the majority to take steps which will increase the maldistribution of the limited resources in the social and health services.

These are just some of the dilemmas, beliefs and expectations which were continually brought to the attention of the Taskforce. They are not all areas which we can resolve, but they are a necessary background for any future evaluation of the health service.

## 1.2 GENERAL APPROACH

The Taskforce spent a considerable time looking at different options which would take account of these views and also address the objectives outlined in our terms of reference. In the end we chose a proposal which is essentially a development of Option 4B of the Health Benefits Review. This option has the state as the dominant funder with services provided through a mixture of state provision and contracts. This was also the preference expressed in most of the submissions made to us.

We have not endeavoured to provide an absolute blueprint, but we do believe there is sufficient detail in our report to enable quick action. There is great confusion at present in the hospital system about new directions and we consider that this uncertainty must be resolved urgently.

We have not tried to provide an ultimate solution. We consider the steps set out in this report are critical for the evolution of the health service. The suggested measures alone, however, would not solve all the problems. Nevertheless, once these recommendations are in place, it would be much easier to steer the system in any direction the community wishes to take in the future. In particular, we have concentrated on improving the operational effectiveness and efficiency of the hospital system. While this will undoubtedly improve equity in terms of easier access, we have not addressed the issue of who should receive government funded health benefits. Questions like these, concerning the relative advantages of continued universality compared to a movement towards targeting, we see as lying beyond our brief.



Our recommendations largely relate to changes in structure. We have not spelt out all consequential changes. We believe that the structure we have developed, which separates the roles of funder and provider, would unshackle those who provide our health services from most bureaucratic control. In the improved environment that should develop from this independence, we expect many dynamic, creative and unforeseeable adaptations to take place.

# CHAPTER 2

## OBJECTIVES

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The terms of reference given to the Taskforce by the Minister of Health and the Minister of Finance on 10 March 1987 were:

### **“AIM OF THE TASKFORCE**

The overall aim of the Taskforce will be to ensure that hospital and related services contribute to the Government's broad health goals, and in particular assist in the achievement of improved health status for all New Zealanders.

### **FUNCTIONS OF THE TASKFORCE**

The Taskforce shall:

- (1) build on the available information base and analysis (ie. that which may be relevant in the Health Benefits Review, the ACC Review, the Board of Health working papers, etc);
- (2) examine the linkages between the hospital system and other health agencies;
- (3) draw up proposals for the overall structure for those health services which are provided by hospital boards, health districts and area health boards. Relationships between those authorities and other components of the health sector should be examined to ensure that a well-managed, efficient, equitable, integrated, responsive, and balanced approach to the promotion and maintenance of the health of the community emerges;
- (4) make recommendations on how its proposals should be implemented, and in what order.

### **PRINCIPLES UNDERLYING THE TASKFORCE'S STUDY**

In drawing up its recommended structures and systems the Taskforce shall ensure that they:

- (1) enable all people to have the widest possible choice of quality health care;
- (2) be responsive to individual and community needs and take account of different cultural perspectives;
- (3) encourage all health care providers to develop their expertise and contribute fully to an effective and efficient health system;
- (4) emphasise that allocation of public funds for public health authorities carries with it an obligation on the part of providers to be accountable for, and efficient in, the use of those resources;
- (5) provide for efficient management of all hospital and related services;
- (6) encourage an effective balance between health promotion, protection, and the provision of care and curative services.”

# CHAPTER 3

## PERCEIVED PROBLEMS

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### 3.1 EQUITY

Equity is a value-laden term. Its definition is subjective and depends on the beliefs of those making the judgement. Even when applied to health care, it incorporates several perspectives. The Health Benefits Review defined equity in the health field as follows:

“The concept of equity implies fairness in distributing the burden of paying for health care and in access to that care by different groups. But there are different ideas of what constitutes fairness. One view sees it as a shared right to a ‘decent basic minimum’ of health services which allows people to buy additional services as they wish and can afford. Another view sees fairness as individuals with similar needs having equal access to health care irrespective of their ability to pay. Still a third view requires policies that produce equality of outcomes in health status across all groups in the population, so that everyone enjoys the best possible health. This last viewpoint involves much wider considerations than the simple focus on barriers to health care shared by the ‘decent basic minimum’ and ‘equal access’ approaches. . . . For the greater part of this report we use the idea of equity in a sense that most closely resembles equal access.”

While we acknowledge a much broader meaning to the term, for the purpose of this report we also have used the idea of equity in the sense of equal access to publicly funded care.

One of the central reasons for governments becoming involved in health care is the concern for fairness and the possible outcomes that would otherwise result. The redistribution of resources by government in the pursuit of equity has been a hallmark of this country’s health and hospital systems from their beginning. Part of the Taskforce’s investigation of the public hospital system dealt with two questions: whether almost a hundred years of government intervention had achieved its intention; and whether the current performance of the hospital sector could reasonably be said to be equitable.

We found that the treatment of different people varies so much, and with so little pattern or logic, that it was inconceivable to us that the results could be regarded as fair. Lack of equity was identified in: the variety in waiting times across the country and between specialties; subsidies which favour medical practitioners over alternative suppliers such as nurses, traditional Maori healers, diet specialists, or acupuncturists; benefits which vary according to where you live and the kind of institution to which you have access.

Medical staff whose expertise lies in the area of diagnosis and treatment are obliged to manage the waiting lists and become arbiters of who receives hospital treatment in many areas of non-acute care. As a result of the present system of funding, the government has largely delegated control of its central concern for equity to health professionals who thus, by default, have assumed progressively more power over areas for which they have received no specific training or brief. The result is a hospital system which, despite the best intentions, is still far from fair in its delivery of services.

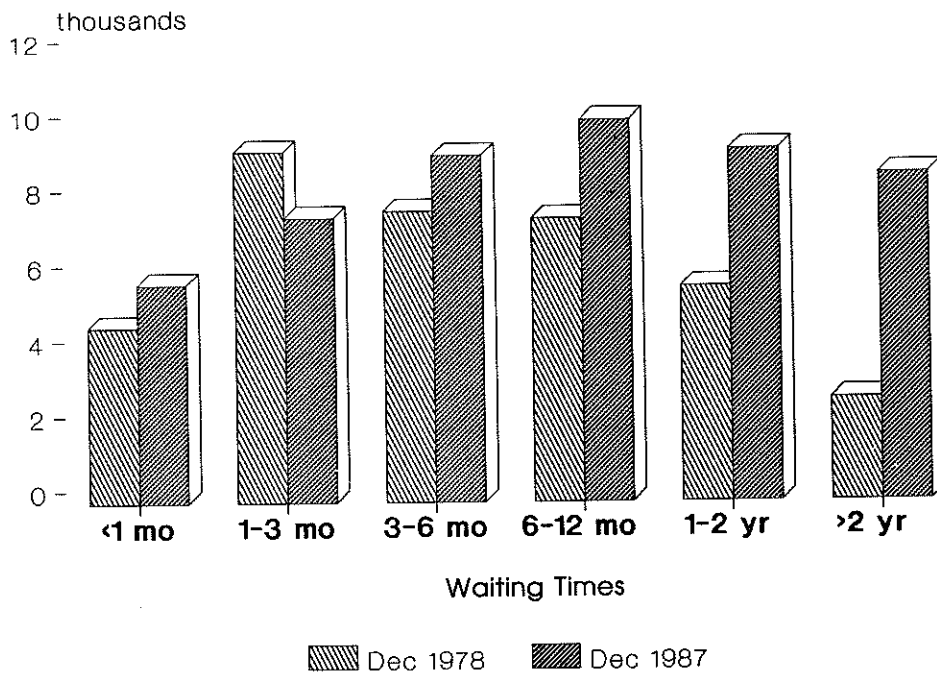
## ACCESS

As far as the public is concerned the greatest failing of the present hospital system is access. Waiting lists for treatment are one of the public hospitals' most obvious problems. People must wait for admission for treatment unless they are victims of accidents or develop acute conditions such as appendicitis.

### Waiting Lists

Today there are over 50,000 people on waiting lists throughout the country who need hospitalisation for some form of treatment. Many have been waiting a considerable time. For instance, of the 50,000 waiting in December 1987, over 8,000 people had been on the list for two years or more, an even higher proportion than in the United Kingdom. This number is equal to the entire population of a town like Greymouth or Huntly. Figure 3.1 shows the length of time spent on the waiting list in December 1987 compared to a decade earlier.

**Figure 3.1: Comparative waiting lists**



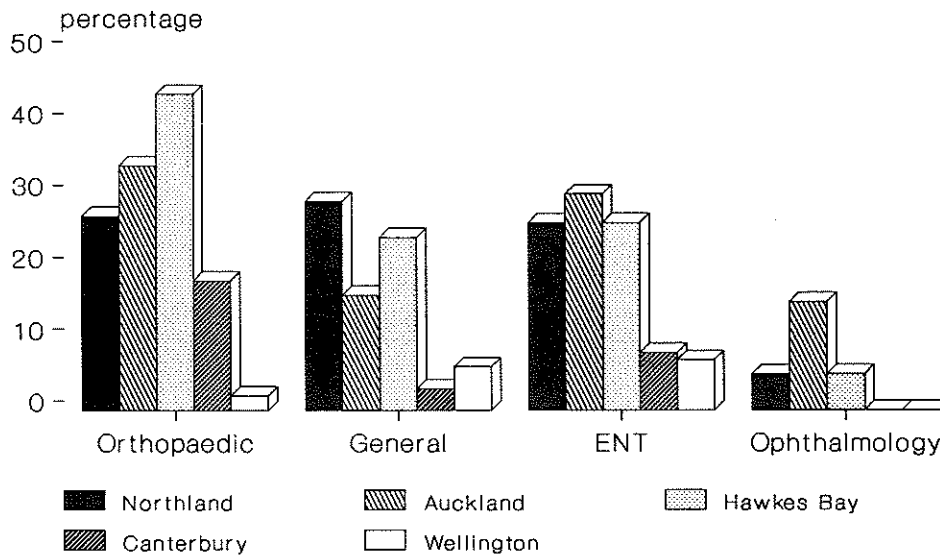
Source: Hospital and area health board returns to the National Health Statistics Centre.

Over the past 10 years the situation has worsened. Not only has the number of people waiting risen by 25 per cent but, on average, they also wait much longer.

The length of the wait varies between regions and according to the operation. In the 1986/87 period, we documented waiting times of at least two years for hip replacements, heart bypass operations and the treatment of kidney stones, cataracts and osteo-arthritis. There has been a 47 per cent increase in the list for cataract operations alone over the past two years. In Figure 3.2 we show the proportion of people in five hospital board areas on waiting lists for four surgical services at 31 March 1987. The variation in waiting times

between boards can be enormous. About two per cent of the people in Wellington wait two years or more for orthopaedic surgery, while in Auckland 33 per cent and in Hawkes Bay 42 per cent of the list wait that long.

**Figure 3.2: Proportion of people on waiting list for more than 2 years as at 31 March 1987**



Source: Hospital and area health board returns to the National Health Statistics Centre.

In addition to those already on waiting lists, it is estimated that there are almost as many people waiting for out-patient appointments with specialists to determine whether they need hospitalisation. (Details are provided in Appendix 1.) For many, the effects of poor health have already begun to undermine their lives.

Numerous letters to the Minister of Health highlight the plight of such people whose only alternative is to pay the full cost of treatment in the private sector. Many are willing to contribute towards the cost but cannot afford to pay the full amount. For example, one person was quoted \$6,500 for a hip replacement, another \$2,350 for a gall bladder operation. Although such surgery is classified as non-urgent, the amount of pain and distress people like these suffer is considerable. During the months, and more often years, of waiting the repercussions are firstly personal and include financial difficulties, job loss, family strain, pain and a loss of mobility and independence; and secondly national, with losses to productivity and increased demands on social welfare spending.

The following examples are not exceptional cases. They are typical of what New Zealanders can expect today if they need 'non-urgent' surgery.

- A Taranaki woman caring for her 93-year-old father has been waiting two and a half years for a hip replacement. She is in considerable pain.
- A Pacific Island man with severe cataracts, living in Auckland, waited two years for an operation. He had no health insurance and because of his extremely limited

vision was unable to work. Instead he was paid a sickness benefit for two years, at a cost of around \$25,000.

- An Auckland woman with osteo-arthritis in both knees has been on the waiting list for two years. Her condition is so advanced that she is unable to walk. She still has not reached the head of the list.
- Another person, with a hernia which forced him to stop working, waited 18 months before being treated. He had no health insurance, his applications to ACC were refused, and he lived for a year and a half on sickness benefit.

Even out-patient services are affected. At the Auckland Hospital audiology clinic the backlog of elderly patients needing hearing aids became so huge that local general practitioners were asked not to refer new patients, while people already on the list faced a wait of up to three years before their first appointment.

The lapse in time between assessment and admission can cause additional problems. A paediatric surgeon told the Taskforce, "A large number of our children are operated upon as day stay cases. Some have been on a waiting list for one or two years and by the time they are called in they have often changed addresses and we have a 30-50 per cent failure to turn up. In private [practice], I can think of only one or two cases in any one year who have failed to turn up for their surgery." The children not only miss their turn in the queue but also leave a gap in the surgeon's operating schedule which could well have benefited someone else on the list. This example is typical of many others given in submissions to the Taskforce.

The New Zealand public hospital system, like that of the United Kingdom, uses waiting lists as one of the ways to ration its services. It is not the number of people awaiting consultation or admission that is the most important factor, but the time spent on the lists. It does not matter whether there are 400 or 4000 waiting if all are admitted within a short period.

Waiting lists are not queues in the conventional sense of queuing for a bus, where the order of priority remains the same. There is always changing order within a hospital waiting list. Hospitals have great difficulty in determining patients' priorities. They tend to respond to plaintive pressure from patients, general practitioners, politicians or the media. The uncomplaining, less articulate and poorer members of society tend to gravitate to the end of the queues. Every waiting list accumulates a number of people at the end who have been waiting a very long time. Their lack of influence is not rectified by the system. The middle class have much more ability to work the system. They are also more likely to be insured, which allows them to opt for private treatment if faced by too long a wait.

The tens of thousands of people on hospital waiting lists have no articulate spokesperson to represent them. Waiting lists have become so permanent a feature of hospital life that, unfortunately, our system has become insensitive to the human suffering caused by them. Queues have lost much of their impact for those who are struggling to maintain present hospital services.

*The lists exist despite the demonstrable fact that there are enough overall resources in the public hospital system to treat all those currently waiting. Unfortunately, many of those resources are not properly utilised.*

Lengthy queuing is normally a sign of organisational breakdown. Once people are ready to purchase, they would not tolerate waiting two years for any other service, or for a car, a fridge, or a stereo system.

## Setting Priorities

Hospital and health services all over the world are now being forced to choose between the multitude of medical treatments and techniques available as costs rise and the variety of clinical options increases. No public health system can afford to offer people all the sophisticated procedures possible today. The discrepancy between what is technically possible and what is generally affordable is increasing exponentially. Financial support for the new developments in the treatment of illnesses and disease can only be met by getting better value from existing resources, increasing the amount of money allocated to health services, or by moving resources from existing treatment areas.

Last year's debate about the viability of a local heart transplant programme is an obvious example. Health professionals and the public were divided in their opinions as to whether the cost involved was warranted or whether those resources should be put to use somewhere else in the system. One person's priorities do not necessarily reflect those of another. This problem of rationing high technology medicine was raised in numerous submissions to the Taskforce. The majority realised that it was not possible to have every high cost procedure available in public hospitals in New Zealand while we maintained a free and universal system. As long as we are forced to make choices, it is important that we have improved ways of gaining public input to those decisions.

There are many other areas where the priorities of patients, who are the consumers of health services, differ from those of the professionals who provide these services and the hospital and area health boards which fund them. For years, women unable to have children have been pressing for more resources to be allocated to in-vitro fertilisation programmes. Such programmes remain a low budgeting priority, even though there is a growing over-supply of beds and other resources for maternity use because of an overall fall in the national birth rate. The problem here is not just one of differing priorities. More importantly, it has to do with the inability of the present system to react to changes in preferences and the difficulty it has in moving resources around; in this example, from an area of contracting need to one where there are insufficient resources.

## LONG STAY AND COMMUNITY CARE

One of the most persistent problems in today's health service is the inconsistency and potential incompatibility of both central policies and the local services offered by area health boards and hospital boards. Central policies are complicated by the present system of benefits and subsidies, the overlapping involvement and conflicting priorities of different government departments and the Accident Compensation Corporation (ACC), and the wide variety of institutions and groups which provide health care.

Because policy has had a bias towards institutional care, there has been little funding given to services which allow people to remain in the community, even though in many situations institutional care is more expensive and inflexible. If this continues it will not be possible to provide for the needs of elderly, mentally ill and handicapped people by the year 2000 without a massive increase in funding. In every country an increasing proportion of all welfare services has become devoted to care of the elderly, a trend which will intensify as we move into the 21st century. It is expected that over the next 50 years real expenditure on health care will have to rise by 60 per cent in order to maintain even the same standard of services.

The needs of these groups of people, and in particular the needs of the elderly, have overwhelmed the voluntary sector. More and more elderly and long stay patients are

being admitted to, or held for unnecessarily long periods in, public hospitals where they occupy expensive beds which would be better used by acute patients. Of the many examples given to the Taskforce, the following submission from just one specialty area, orthopaedics, illustrates this problem:

“We are responsible for the admission of some 500 elderly patients with femoral neck fractures per year. We find that the orthopaedic need for in-patient, base hospital care is finished between five and ten days after surgery. However, the injury, and the breakdown in the social pattern, often mean that these elderly patients require temporary or permanent placement in an institution, or a change of type of institution. Invariably, this takes a vast amount of time and such patients may sit in orthopaedic wards for anything up to four to six months. They sit in a busy orthopaedic ward, getting no geriatric rehabilitation, and having no treatment provided from the medical staff responsible for their care.

“I have estimated that we could do 300 [more] total joint replacements in a year in the beds occupied by such patients who have no need to be in the hospital and, indeed, are in a very bad environment in terms of their requirements for geriatric rehabilitation.”

## **THE ACCIDENT COMPENSATION CORPORATION**

The ACC has major implications for the health system simply because it is a major funder of health services. The scheme was originally intended to cover just income earners and those involved in motor accidents. Premiums were to be paid for that coverage. By the time the Accident Compensation Act was introduced in 1974 it had been amended to cover non-earners whose premiums were to be paid by the State. One result of this amendment is that *state* support can differ greatly for earners and non-earners with similar health problems, depending on whether the problems result from accident.

A recent case illustrates the current situation. An elderly woman fell over and broke her hip. She received immediate treatment, home help, free transport to and from hospital and a lump sum of \$5,000 in compensation from the corporation. While this woman was assured health care, another woman crippled with arthritis, where the effects of pain and mobility are similar, cannot expect to receive anything apart from the standard welfare benefits to which she may be entitled. She would probably have to queue for treatment if she goes to a public hospital and would have to pay for help at home and her transport.

In addition to the extra payments, the accident patient can avoid queuing by receiving free care in private hospitals at ACC expense. The Accident Compensation Act and the Social Security Act stipulate that public hospitals cannot charge the corporation for work undertaken on behalf of ACC patients. The public hospital system is unable to take on much of the burden of ACC work in timeframes acceptable to the ACC; and the staff required for non-ACC patients, particularly in physiotherapy, surgery and anaesthetics, receive higher remuneration and more attractive working conditions when they treat accident victims in the private system. Therefore ACC patients are able to avoid the queues that non-ACC patients in public hospitals have to face.



## RESPONSIVENESS

In the course of 12 months of written and verbal submissions, the Taskforce gained the definite impression that people considered health and medical care too important to be left entirely to the decisions of doctors. There is considerable dissatisfaction with our health services and their lack of responsiveness to those who use them. This criticism of lack of choice and control is growing.

Historically, lay people have had very little input into health services. The apparent indifference of health professionals to many issues that concern women's health and Maori health were two examples cited repeatedly. This insensitivity to the needs of particular groups or individuals within our society, the non-involvement of patients in making clinical decisions which affect their own bodies and health, the services' illness orientation, and failure to practise the doctrine of informed consent, are all common accusations leveled at those within the health system. When consultation with the general public or the individual does take place, it is usually regarded as token only.

The recent National Women's Inquiry into the treatment of cervical cancer raised numerous questions about health professionals' attitudes towards patients. The traditional concept of a caring medical profession disciplining itself to ensure that doctors acted satisfactorily in their primary role, as servants of their patients, may not be as secure as before. Media coverage of the Auckland cervical cancer inquiry reported comments made by a hospital board clinical administrator which amply illustrate the way in which the medical profession has jealously guarded its clinical freedom:

"... [He] told the cancer inquiry ... that he would have intervened in a hospital's procedure only if there was illegal activity and not if patients' health was threatened.

"The board upheld professional freedom by permitting medical staff to 'practise medicine the way they wished to, according to their professional beliefs, training and experience and to currently accepted methods and standards'. . . . He had absolute faith in the integrity of doctors, he said.

"Doctors cherished clinical freedom above all else and resented anybody looking over their shoulders, [he] said."

(The Dominion, 22 October 1987)

When a hospital board recently requested that patients' complaints be routinely referred to it, board clinicians refused to support the proposal. Statements and incidents such as these, whether fully accurate or not, whether reported in context or not, reflect the feeling amongst some people who submitted opinion to our Taskforce, that medical behaviour and the control systems in hospitals are lagging behind community expectations.

There are growing anxieties about whether the present rudimentary peer review systems, initiated by and under the direction of the medical profession alone, are evolving along appropriate lines. There are further questions about the adequacy of access to legal and other forms of redress for patients, and of corrective measures for unsatisfactory professional behaviour. Other concerns relate to the nature of information available to patients in order to place them in a position where they can make fully informed choices and thereby give fully informed consent. We have been made very aware that the role and limits of clinical judgement in contributing to health service decisions are under scrutiny.

It would appear that the public continues to have confidence in doctors, and in the public and private hospital systems generally. There is, however, a growing disenchantment with lay people's apparent inability to bring about change, to have their complaints given weight, or simply to be treated as intelligent adult people. There seems to be an attitude prevalent among some staff in public hospitals that if patients wish to complain about services then they 'should go privately', or 'they don't know what's good for them'.

The complaints from women's groups, and the criticisms of Maori people about the system's lack of cultural sensitivity, represent the disquiet of people who want a response to their special needs. Obviously not everyone within groups as broad as these will have the same concerns or health priorities. Nevertheless, they operate as a group from time to time on specific or general issues in an attempt to give more power to the requests from individuals within those groups.

It is not surprising that when hospital or area health boards receive complaints about a hospital and its services or staff, their immediate reaction is defensive. At present boards not only fund the services in their hospitals but also provide them. They have overall responsibility for the day to day running of the hospital and all its activities. Therefore it is *their* hospital, *their* services, *their* staff. The complaint reflects back on the hospital or area health board. The board and staff are less likely to respond positively to patients' or even to their electors' complaints while this dual role and conflict of interests continues.

We believe our recommendations will substantially improve these issues of equity in our public hospital system.

### **3.2 EFFICIENCY**

The health system costs tax-payers over \$3.4 billion per year with the hospital sector accounting for \$2.4 billion (1987/88 Estimates). When debt servicing is excluded, health care is the second largest item of government spending after Vote:Social Welfare and represents approximately 18 per cent of government expenditure. Total spending on health accounts for about seven per cent of gross domestic product (GDP).

Hospitals form the largest industry in New Zealand and are the largest employers in most towns where they are situated. They employ 50,000 people, double the combined number in the clothing and footwear manufacturing industries, over six times as many as the pulp and paper industry and 12,000 more than the labour forces of all meat works and dairy factories. As well as being the biggest business undertaken by the state, hospitals are also more complex than the other services provided by government.

Therefore hospitals' importance to the economy, and government's role within that system, is of crucial significance. Over the last two years (ending 31 March 1987), largely as a result of increased salaries negotiated by doctors and nurses with government, taxation funded expenditure on hospitals has increased by over 50 per cent in money terms and almost 20 per cent in real terms (CPI). Despite that increase, there has been only an insignificant increase in the services provided in the public hospital system overall.

### **THE ARTHUR ANDERSEN REPORT**

With these facts in mind the Taskforce commissioned Arthur Andersen and Company to report on the relative efficiency of the hospital sector in New Zealand. Little financial

data on the sector's performance was available so the range of results in the final report reflects the fact that an assessment has had to be made.

The Arthur Andersen study looked specifically at work practices within New Zealand hospitals in terms of New Zealand practices. It was designed to compare the relative efficiencies of units working within a sample of New Zealand hospitals. The comparisons were mainly between different units in the same hospital and between units doing similar work in other New Zealand hospitals. Some comparisons were made between North American and New Zealand practices but that was not the primary focus of the exercise.

The study concluded that huge gains in terms of resources available for re-allocation or for other services are possible in the hospital sector. They range between 24 and 32 per cent of the current operating expenditure, approximately \$450 million to \$600 million in 1986/87 values. The first figure is equivalent to the 1986/87 government grant for the Auckland Hospital Board's operating expenses. The second is almost as large as the combined operating grant to the Auckland and Canterbury Hospital Boards for 1986/87, the two largest boards in the country.

The significance of these potential gains is made even more obvious by comparing them with other areas in the public and private sectors. The more conservative figure of \$450 million is greater than government spending in 1986/87 on the police service or university education and equal to the total unemployment benefit. It is more than the value of our greasy wool exports. The larger figure of \$600 million, which Arthur Andersen still regards as conservative, is almost as much as the total domestic purposes benefit paid in 1986/87 or all government expenditure in secondary schools that year and only slightly less than the value of car, truck and bus imports in 1985.

As the Arthur Andersen study enumerated its findings and analysis, several recurring themes became apparent. There was an appalling absence of the kind of data needed to enable the sector to be properly managed. There was, in fact, little consideration given to the issue of management at all by the health service as a whole. Yet most of the gains identified in the report were directly connected to the better management of various hospital sector activities.

Despite this general inattention to good management, some areas throughout the country had accomplished good levels of efficiency. They were not, however, representative of other departments or areas in the same hospitals or boards. They reflected individual managers' excellence, whether they be doctors or laundry managers. Arthur Andersen concluded that the performance of these people set a standard that could be matched elsewhere in our system. When services themselves were compared, the more efficient performers usually had good or very good reputations as well, so that their quality had not been compromised.

The major gains which the Arthur Andersen Report considered were achievable are:

	Range	
	\$M	\$M
Reduction in hospital length of stay	180	198
Reduction in hospital facilities	24	26
More efficient hospital departments	80	104
More efficient support departments	52	68
Better incentives within the system	115	205
Total gains	451	601

Some of these 'savings' result from correcting misapplied funding. For instance, in cases where a mixture of social and other reasons prevent patients being discharged from hospital when they are fit to leave, it would be more appropriate to provide community care, access to rest homes, or recuperative beds, all of which cost less than acute hospital care. Shortening the length of time people spend in hospital would require a greater number of these alternative facilities.

The gains identified by the Arthur Andersen study did not include any savings from long stay geriatric or psychiatric care, although these are potentially very substantial. For example, the Arthur Andersen team found that the lowest cost for a geriatric patient in an acute hospital ranged from \$64 per day to \$199 per day in a small hospital, and between \$99 and \$657 per day in the largest hospitals. The substantial savings that would result from improving the efficiency of the delivery of care in geriatric and psychiatric hospitals could be available to pay for the greater nursing and community care that would be necessary as a result of shorter bed stays for elderly patients in acute beds.

The Arthur Andersen team and the Taskforce are not alone in believing that there are significant gains to be made. Most people within the hospital system also believe that there is major potential for improved hospital efficiency. Inevitably there will be some who doubt these results and who believe they can detect bias or error in the report. Some will accuse Arthur Andersen of lack of empathy with New Zealand social systems. The Taskforce, however, is confident of the general directions and findings of the report.

The hospital sector is made up of many talented and dedicated people. It has a huge task. In 1986/87 the sector recorded 448,000 admissions to hospital, 4,370,000 out-patient treatments, 52,000 births and 62,000 new day patients. The Arthur Andersen study and this report do not discredit hospital staff, rather the system they work under. In the main the hospital and area health board system, the Department of Health and successive governments are the real culprits and the present situation is no credit to them.

## COMPARATIVE COSTS

The percentage of gross domestic product (GDP) spent on health care varies almost directly according to a country's standard of living. Third world countries spend almost nothing on hospital care; rich countries spend more on health and hospital care, just as they do on holidays, restaurants and other discretionary services.

New Zealand spends approximately seven per cent of GDP on health care with just over four per cent going to hospitals in 1986/87. The Health Benefits Review report, "Choices for Health Care", stated that this country spent less per head (in relation to GDP) on health than comparable countries. However, although Health Benefits Review figures and those commonly used in compiling statistical data show that the health care share of GDP is below the OECD average, we consider those figures to be an under-estimation. Past New Zealand estimates have excluded expenditure on areas such as product inspection and other government department spending on health which have been included in health statistics by overseas countries. If these items are also included in our statistics, they lift the Health Benefits Review's figures for 1986/87 from between five and six per cent to about seven per cent. (Preliminary estimates of New Zealand health care expenditure are given in Appendix 2.) Overall, we doubt that there is much significance in the share of GDP devoted to health care. Nevertheless, it is a figure often quoted.

The percentage of GDP going to hospitals is similar to that of Canada, Australia and England, and slightly less than in the United States. This is surprising as most indicators show that the percentage of GDP spent on health care varies according to a country's per capita income. New Zealand, with a per capita income about two-thirds that of Australia and half that of Canada, still spends about the same percentage of GDP as those countries spend on hospitals.

## ALTERNATIVES TO IN-PATIENT CARE

Since 1977 hospital and area health boards have been encouraged to develop good community and day care facilities in order to replace their heavy reliance on in-patient care. Progress has been slow and there is still considerable potential for more ambulatory surgery (admission and discharge on the same day) and for shorter hospital stays. The Arthur Andersen Report commented:

“The most costly and intensive form of health care delivery is a day of in-patient care. Bluntly stated, many days spent by patients in hospital beds do not have to be. Some of these days could be saved by treatment in a physician's office or other out-patient settings. The hospital stay can often be shortened [with no hazard] to the patient. All of these actions require incentives to change existing practice.”

Surgeons and post-surgical staff are reluctant to change their procedures and roles to practise day surgery. Boards actually have a perverse incentive not to provide extramural services. For although it is more effective and costs less to treat many patients at home, it also frees up a hospital bed for another patient on the waiting list, thereby increasing the board's total expenditure.

## PRIMARY CARE LINKS

Integration between the primary and secondary sectors of health care leaves a lot to be desired. Information is rarely shared between these two sectors and in cases where a general practitioner's information could have been made available, it is often not requested by hospital specialists. It should be realised that the current duplication of laboratory tests, whereby tests undertaken in general practice are repeated by a specialist, and then often yet again on admission to hospital, use items of service which are funded from the same common pool of government revenue.

Part of the cause for this poor communication and interaction results from the different way in which the two sectors work. It is difficult for general practitioners to build up a relationship with the depersonalised service of public hospitals. There is often no one member of staff who follows a referred patient through from their pre-admission consultation to discharge. Even treatment at out-patient clinics may be done by a series of staff. The lack of follow-up on patients after they are released from hospital, is partly due to the absence of a clearly identified manager for each case.

There is no incentive in the system to improve communications between the hospital specialist, the general practitioner and the patient. The present payment system for general practitioners is such that the time spent with patients and colleagues in hospitals does not earn income. No allowance is made, for instance, for travel time or consultation

periods with colleagues. As a result, one of the more useful gate-keeper functions of the general practitioner—the capacity to restrain hospital expenditure—is not being realised.

We believe our recommendations will substantially improve these efficiency problems.

### 3.3 MORALE

Last year the Director-General of Health, Dr George Salmond, said of the hospital system, "Information systems are deficient and management is weak. There is little pride in, or loyalty to, the service. Sectional interests prevail and incentives to staff are often perverse."

There is a serious morale problem within the public health and hospital systems. The headlines, reports, commissions, committees and general debate are the public face of the problem. This process of review is not new. It has been going on for years at the instigation of different governments and government departments. Apart from reams of paper the results have been negligible. It would be surprising if those who work in the health and hospital systems, as well as many outside the systems, had not developed a deep cynicism to both the process of analysis and the political will and ability to bring about change and improvement.

Almost nobody within the system believes it is excellently run. Frustrations are caused by difficulties in getting access to resources, rigidity in management structures, seemingly mandatory bureaucratic delays in approval for many minor matters, rigid employment systems, and the inflexible way in which resources are used and distributed. All these factors hamper people's ability to get on and do what they are paid to do.

Loss of morale is also evident among hospital boards. Originally the boards were responsible solely for secondary care, but as time passed they were expected to become more involved in primary and community care as well. The simultaneous pressure for increased spending on primary health services in a period of growing waiting lists and rising pressure on hospital services, has made boards wonder what their role is and how they might best reconcile these conflicting demands.

The problem is not helped by the present triumvirate or consensus management structure. There is, according to the Arthur Andersen Report, a lack of well developed management skills throughout the public health system. Uncompetitive salaries and restricted entry make health sector management positions unattractive to high calibre managers from outside the health services.

Finally there are deficiencies in the deployment of clinical staff. These include unequal distribution of medical staff (between rural and urban centres, primary and secondary sectors, and junior and senior levels), professional isolation of staff in peripheral hospitals, poor cooperation between doctors and other health professionals and between doctors themselves, and the inappropriate use of skills and training.

Few of the problems we identified during the past year related to the medical skills or the dedication of staff within the health service. The system employs a great number of highly motivated and highly trained people who are doing the best they can within a restrictive and often perverse environment. The overall quality of the services they provide ranges from adequate to excellent. Medical staff include some of the best intellectual talent in New Zealand. In their tertiary training young doctors have more education resources spent on them than any other professional group. To then subject these people

to a system which frustrates and wastes their natural and learned skills is particularly indefensible.

We believe our recommendations will substantially improve morale throughout the health services.

# CHAPTER 4

## MANAGEMENT DEFICIENCIES

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The public hospital problems outlined in the previous chapter are indicative of serious deficiencies in the system. They are some of the outward signs of a management structure that is over-centralised, bureaucratic, inflexible and confused. Any attempts to bring about change are frustrated at all levels. The people who have to work within this environment are left without sufficient incentives or autonomy to solve these and other problems.

In October 1983 the National Health Service Management Inquiry Report in Britain made the following observations:

“We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important. In many organisations in the private sector, profit does not immediately impinge on large numbers of managers below Board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking. All things that Parliament is urging on the NHS. In the private sector the results in all these areas would normally be carefully monitored against predetermined standards and objectives.

“The NHS does not have the profit motive but it is, of course, enormously concerned with control of expenditure. Surprisingly, however, it still lacks any real continuous evaluation of its performance against criteria such as those set out above. Rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare. Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question.

“It therefore cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake.”

In our opinion, the comments of the NHS Management Inquiry could be applied equally to the New Zealand hospital system.



## 4.1 MANAGEMENT PRACTICES

### TRIUMVIRATE MANAGEMENT

The New Zealand hospital system is run by triumvirate or consensus management. The three executives—a doctor, a nurse and an administrator—represent the three major work groups in hospitals. Not only is this structure applied to boards' executives but usually to each institution controlled by the board and often to each department within them as well. Rather than authority and responsibility lying with one person, it is shared between three, each with the power of veto. At few levels does one person have full responsibility for managerial decisions. The NHS Management Inquiry, in commenting on this management structure, remarked that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge". The troika concept was imported originally from the United Kingdom where, sensibly, they have now abandoned it. No other hospital system employs this structure and it contrasts with the general management approach used in all other sectors of the economy.

Triumvirate management stifles leadership, dilutes accountability and makes for poor management relationships at lower levels of the organisation. It has proved "highly inefficient" in the words of one hospital department head who continues, "No one person is prepared to accept responsibility for inappropriate decisions, and bad compromises are achieved where a decision has to be taken by consensus."

One of its characteristics is that each professional group sees its member of the troika as its representative rather than as a manager. The management of medical staff and allied health professionals is ostensibly the responsibility of the medical superintendent, one member of the triumvirate. However, in the main that managerial responsibility is ignored. Instead, when medical heads of department are appointed they may, and often do, see their job as representing staff, not managing them. This leads to weak management and a greatly increased opportunity for professional groups within hospitals to take over the management role and unduly influence decisions and work practices to their advantage, rather than for the benefit of the organisation as a whole.

Other members of the triumvirate tend to have the same relationship with their staff. As the previous Minister of Health, Hon. Dr Michael Bassett stated, a manager should "not be in a position where you are subject to management by ambush from your employees. . . . Top management must be able to manage. It must not be managed by the workforce." Some results of this lack of management are inadequate co-ordination, competition between professional groups, and a lack of clarity about staff members' roles, duties and responsibilities.

### MISUSE OF STAFF

The extent of boards' lack of autonomy and authority, and the unsatisfactory and often inefficient way that it affects management issues, is demonstrated in the way health professionals are employed.

Staff wages and salaries account for approximately 75 per cent of boards' operating expenses yet the Health Service Personnel Commission (HSPC) have negotiated the central awards and general conditions of employment for health services staff.<sup>1</sup> The

<sup>1</sup> The State Sector Bill abolishes the Health Service Personnel Commission and brings hospital boards and area health boards broadly into line with the state provisions. Central negotiation of remuneration remains under the control of the State Services Commission.

involvement of relevant management staff in those employment decisions has been minimal and no allowance has been made to tailor salaries to local conditions. Boards are now free to hire their own medical staff but not to negotiate salaries or conditions of employment. The establishment of any new senior nursing position, charge nurse and above, still requires approval from the Director-General of Health.

The rates of pay and conditions of employment do not encourage good performance either. Staff and doctors within the hospital system are given 'tenure' very quickly. Once they have 'tenure' they are regarded as being entitled to their job for life, irrespective of whether their specialty is still needed and whatever their productivity. Senior medical staff are paid on the same basis, with no account taken of their workload, specialty, or the scarcity of that specialty. Consultants called in regularly over and above the hours they are contracted for, because of the kind of work they do, are paid no more than those who work minimal overtime—perhaps 10 hours a week. The nature of their work contract does nothing to encourage productivity.

The irony is that the arbitrariness of these and other employment processes for doctors and any staff essential to the running of a hospital induces huge consequential costs. These staff members are central to productivity yet hospital management, either in misguided attempts to achieve economy or through difficulties in recruiting because of arbitrary pay scales, can cut efficiency by allowing staff shortages to develop in these key areas. For instance, of the \$1.9 billion spent in running hospitals in 1986/87, doctors' combined salaries account for less than \$160 million, nine per cent of hospital operating costs. Therefore, to allow vacancies for doctors to persist causes great waste of overall resources as the other 91 per cent of the costs continue regardless, but throughput ceases. No other commercial enterprise would tolerate failure to recruit essential personnel because of such arbitrary employment restraints.

Although, in theory, hospital staff are meant to operate in teams, the absence of a coherent management policy can lead to a lack of cooperation. The troika structure has allowed the current system to be manipulated and hijacked by different groups of health professionals. For instance, decisions made by nursing staff, entirely in isolation, have caused operating theatres to remain idle and wards to close. One opinion expressed to the Taskforce was that in recent years health providers have become over-professionalised and relatively inflexible in the way they see their roles.

Key people within the system have indicated that they could double or even treble their productivity if the public sector was organised, like the private hospital system, to take account of the way they worked. If it was in the interest of the boards to institute change and they had the necessary power, the costs of providing incentives to achieve this would be insignificant compared with the benefits in the overall use of resources.

## **LACK OF MANAGEMENT INFORMATION**

The New Zealand hospital system is characterised by very poor management information. Management accounting and costing systems are almost nonexistent. Current information and accounting systems are geared nearly exclusively to measuring inputs and even in this they are deficient. Simple operating statistics are difficult to obtain and are often inconsistent and out of date.

It is very hard to secure any useful detailed information on what is purchased through present spending. No standards are set for the cost of services and no comparisons made

between hospitals. We find this absolutely extraordinary. No enterprise should be conducted this way.

This total lack of proper costing information was a major obstacle in our evaluation of efficiency. We expected that the paucity of data available on critical issues, including costing, would mean our work would not be as penetrating as we would have liked. What surprised us was the extent of this deficiency. The Arthur Andersen team encountered the same problems. It was unable to evaluate critical areas, such as the use of operating theatres, because of the absence of the most basic information. As the team noted, that absence in itself is an indictment of the system. Unfortunately many boards seem to think expenditure on accounting and information services is a waste of money and would rather spend it on clinical staff. In such large enterprises this is a misguided belief. Furthermore, this situation has been commented on regularly and unfavourably ever since the Report of the Consultative Committee on Hospital Reform in 1953. It is a public scandal that basic performance data is still not available for a sector of this size.

## **LACK OF COST CONSCIOUSNESS**

An inevitable consequence of inadequate information is that none of the people who make decisions are aware of the cost of the resources they use or misuse. Therefore they cannot take costs into account when considering different courses of action. In particular, they cannot be aware of the opportunities lost by their decisions.

Lack of cost consciousness undermines efficient resource allocation at all levels within hospitals. Many major hospitals do not require heads of departments to control the costs generated by their departments. Therefore key staff are not in a position to account for the output of the team with whom they are working. The use of the bulk of hospital resources is determined by the decisions of individual doctors and nurses who have clinical but not resource accountability. The Arthur Andersen study shows that the incidence of efficient departments is entirely random. The presence of one well run productive department did not mean that all departments in the same institution were performing well, or that similar departments in other hospitals were efficient. At present, results clearly depend on the leadership of each department, and not on any overall management within the hospital or by the hospital or area health board.

Most clinicians resent interference from others in work practices that have major implications on the use of resources: admission policies, discharge criteria, patient treatment options, waiting list decisions, use of operating theatres and use of technological developments. Many doctors believe they alone should determine what procedures are undertaken, when and where, with no regard for budgetary approval or total cost. Others accept that resources are limited and that such decisions must come under management scrutiny. They argue, however, that if clinicians were given the necessary costing information, they themselves could act as more effective and responsible managers of the resources they control. We strongly support this approach to clinical budgeting.

According to one submission received by the Taskforce "there is no real mechanism which prevents a surgeon using a new, experimental and very expensive form of total hip implant, when an older, more established and cheaper device is available. Naturally I would be keen to experiment and innovate but I believe this should be done in a controlled way, and not at the whim of individuals who are not responsible and seldom have any feeling for the cost differentials involved."

The extent of this behaviour not only applies to high cost interventions but also to the batteries of unnecessary diagnostic tests ordered by a minority of clinicians. With good costing data, responsible clinicians would be in a better position to point out that such behaviour was not only wasteful but unethical—unnecessary treatment for some denies effective treatment to others.

## LACK OF PRODUCTIVITY MONITORING

Another remarkable feature of the hospital system is an almost total absence of productivity measurement. Doctors, nurses, and the institutions and clinics which provide public health services, do not have their productivity or workload evaluated or measured. In fact, most do not even have guidelines to tell them what their productivity should be. As a consequence, both the Arthur Andersen study and our own showed that massive variations exist in productivity between similar departments in different hospitals.

These deficiencies in the quality of the information available automatically excluded some major services from the Arthur Andersen study. There was so little information on which to make valid judgements about geriatric and psychiatric services—two health areas which use considerable resources—that they were omitted from the report. Yet they are areas that are frequently criticised in terms of the quality and quantity of their service. For similar reasons the team was unable to investigate the possible efficiency gains in hospital pharmaceutical care, the engineering and maintenance activities of boards, or the scheduling of operating theatre use. As this last area is one of the basic factors in waiting list times, bed utilisation and hospital throughput, the lack of such information borders on negligence.

Naturally, as there is no measurement of output there are no incentives to increase it. In fact most of the incentives within the system restrict productivity rather than encourage it. Because of the complete lack of proper management information there is great difficulty in moving resources from low priority areas to new priorities, or in improving efficiency and productivity.

The public health service is the largest sector in the economy where people are paid for what they spend rather than for what they do. The other major sector paid for expenditure instead of output is education, a vastly simpler service without the multiplicity of diverse and complicated technical influences, machinery and skills that exist in the health system.

Payment for output rather than reimbursement of costs is an issue which the Taskforce has specifically addressed in its recommendations.

## PRIVATE SECTOR CONTRASTS

The majority of medical specialists work in both the public and private sectors and the way the two areas employ these doctors is very different. In the private sector the range of services doctors provide is more limited than in the public sector. Where the services provided are the same, their private sector productivity is consistently higher than the same doctors' output in the public sector. If forced to make a choice between sectors, there is little doubt that many would choose the private for the greater freedom it gives to work more intensively in an environment over which they have some control.

The public sector has its attractions and compensations of course. Probably the most important is the sophistication of the medical and surgical work done there, and the

support and stimulation of working with a wider range of staff. The number, variety and complexity of the treatments undertaken are much greater than in private hospitals at present. Public service also entitles doctors to a pension scheme. But, despite these positive aspects, for some doctors a more basic motivation is the element of social service obligation in their public work.

The difference in the pervading culture of the two sectors, the one encouraging efficiency through financial incentives and the other relegating it to a low priority, may affect staff behaviour in a way that causes even further reductions in public sector productivity. Rigid demarcation lines in work allocation in the public sector prevent surgeons, for example, undertaking tasks they carry out when the occasion demands in their private work, such as wheeling a patient into theatre when they are ready for them rather than waiting for an orderly. It is not an option available to them in public hospitals, unless they want to court the possibility of industrial action.

But there are also claims that staff who work in both sectors compound inefficiencies at times. For example, theatre sessions, out-patient clinics and other duties are sometimes cancelled at the last moment with very wasteful consequences. The relatively unproductive performance of some doctors in public hospitals, compared to their performance in private hospitals, has a lot to do with the lack of financial incentives and the less personalised doctor/patient relationships. Without clear contractual obligations in the public sector, and because they have personal commitments to patients in the private sector which they cannot or do not wish to change at short notice, their time in the public sector becomes less effective.

At present, senior doctors in some specialties are paid less than half what they earn in the private sector and consequently many of them regard their service in public hospitals as charity. In these circumstances they are often unprepared to take the extra steps they would in the private sector, such as visiting and releasing patients at times other than those most convenient to them.

There is an appalling waste of resources as a result of these employment practices.

## 4.2 UNDERLYING CAUSES

The management, or more correctly lack of management, which we have outlined has many causes, the most important being the way we pay for hospital services. Money is voted each year by Parliament and given to hospital or area health boards to be used to provide an unspecified range and quantity of services. There is almost no focus on outputs resulting from the boards' decisions and instead a panoply of direct controls are used in an unsuccessful attempt to limit the misuse of the funds.

## CONSTRAINTS

Area health boards and hospital boards are far from the decentralised decision makers that successive Ministers have suggested. The legislation governing the boards still leaves most power with the Department of Health and, more particularly, with Ministers. For instance Ministers can direct boards; determine the extent and standard of boards' services; must approve the closure of a hospital, contracts with teaching institutions, by-laws, land acquisition, the boards' choice of bank, the grants they make to other agencies, and so on. Currently, services cannot be contracted out without the approval of the Health Service Personnel Commission. While parts of the controlling Acts appear to delegate power to

the local level, the duties and rights of the Minister would seem to countermand and override that.

In effect the boards have little autonomy and this is the cause of some of the greatest frustrations for those who are meant to manage. The division of responsibility can also be used to avoid taking action. Each group then blames someone else for the resulting inaction. For instance, major capital items are funded centrally by the Department of Health. The process is quite separate from the allocation of operational money and involves a series of checks and balances. This results in very long lead times and diffuse responsibilities for funding programmes. When mistakes occur there is ample room to avoid the blame. The present redevelopment of Christchurch Hospital, which makes no specific provision for ambulatory surgery, is an example. Some surgeons claim they were blocked by the nurses, the nurses claim it was the surgeons' decision; the anaesthetists claim they were blocked by administration, while the medical administration blames the Department of Health.

Lack of planning also means that new buildings do not necessarily guarantee extra services. One Taskforce submission wrote, "... we frequently end up with the bricks and mortar, but no money for staff or services, resulting in a great waste of time, effort and unoccupied space." Examples quoted included a ward at Tokoroa Hospital built under some political coercion in an unsuccessful, as it transpired, parliamentary vote-catching exercise; a 32 bed psychiatric unit in Rotorua which was opened in 1983 after eight years of planning, but with insufficient funding to this day to operate more than 16 beds; and Hastings Hospital's new \$3 million 40 bed geriatric assessment and rehabilitation unit which was still idle seven months after completion because there was no money to staff it. Far too often decisions are overly influenced by news media and political pressures with insufficient account taken of the practicability of the proposals.

Boards' decisions are biased by the fact that both interest and principal on any loans they take up are repaid from Vote:Health. This means that to them major capital items such as buildings, plant and equipment are free. An obvious result is the waste of buildings and equipment which turn out to be placed in the wrong area, or of the wrong design, or no longer needed.

## CONFUSED ROLES

Management is also hampered by the boards' dual roles as funders and providers of health services. The extent of the responsibilities attached to both roles and the natural conflicts and tensions between them, mean that neither are well done. The effect of these tensions is well expressed in the following submission:

"Currently the board receives a bulk allocation which is used to 'purchase' resources—staff and supplies—which are devoted to providing health services in the district. The level of service is governed by the resources available, and it is difficult to quickly transfer resources from one service to another as circumstances and demand changes.

"In such a situation, what accountability there is concentrates on the inputs to the departments within institutions. Budgetary control is concerned with ensuring that the cost of inputs remains within the funds allocated to the departments. Little recognition is given on an ongoing basis to changes in demands on services, or on the outputs produced. Changes are generally reviewed only

once a year and there is little incentive to provide more efficient services. Funding may be provided whether or not there is any satisfactory output.”

Area health boards and, to a lesser extent, hospital boards must also make choices between the kinds of services they are funding. Boards are inevitably influenced by their ownership of services. They tend to own treatment services which means that other areas like community health, already under-funded, are further run down adding to the illness orientation of our health services.

## **ELECTED BOARDS AND RESPONSIVENESS**

The complexity of all these demands and responsibilities suggests the need for special qualities, expertise and skills. The present method of choosing board members leaves this very much to chance. Hospital boards are generally made up of retired people, staff, and husbands and wives of staff and rarely include many people with business expertise and directorship skills. Board members are seen as representing their local community and therefore as being responsive to local needs. But they are also accused of being too parochial in outlook. Furthermore, they are frequently unwilling to confront controversial issues.

In our public hospital system the priorities given to different services, and the type of service provided, are based on the decisions of administrators, clinicians and elected boards. Management decisions are subject to a whole array of conflicting interest group pressures from consumers as well as from staff who provide the services. Even so, electoral processes cannot adequately gauge or reflect the strength of individual preferences. Consumers at present have no way of directly determining the pattern of services supplied or having their wishes and needs given priority.

### **4.3 CONCLUSION**

The first priority in reforming New Zealand public hospitals must be to make them more efficient and responsive to the consumer. They must have basic information systems, know their costs, have good role definition and accountability.

To generate and sustain more efficient management, there must be a fundamental change in the way payments are made and responsibilities are defined. Managers need to have increased flexibility, but in return there must be effective methods of making them accountable. The following chapters outline the proposals recommended by the Taskforce in answer to 35 years of repeated criticism of the same structural deficiencies. We believe they contain the mechanisms necessary to produce a more efficient and more equitable hospital system.

# CHAPTER 5

## UNSHACKLING HOSPITALS

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The preceding chapters in this report show that the main problem in New Zealand hospitals is poor management. There is one principal reason for this. Good management requires accurate and relevant information and appropriate incentives to use it. Normally enterprises providing goods and services obtain their most important management information from the prices they pay for their inputs and the prices they obtain for their output.

Unlike most other enterprises in the New Zealand economy, public hospitals do not know the value of their output. Thus they have only one side of the necessary management information. Without knowing the economic value of their output, knowing their costs is of little use. The price of a service in a competitive market shows management the maximum amount they can spend. If their costs are above this price they have to reorganise their activities to at least get them down to this level.

The reason public hospitals do not know the value of their output is that government grants their money in bulk. They are then expected to do the best they can within their allocation. This process of merely supplying a block grant deprives hospitals of the very information essential to management—the value of what they produce.

It is clear that the Government wishes to remain the dominant funder of hospital and related services. Our solution to this situation is to propose a structure which retains government as the main funder and provider, but introduces a clear separation between the two roles. This separation enables a market to be created in which prices are set by modified competition between hospitals. The information available on comparative costs and prices throughout the system will be a powerful factor in this modified competition. Thus the best performers will have an influence which will pervade the system over time, even though they may never be a direct “competitor” with more distant hospitals.

Even this limited market would enable a radical change in management within hospitals. When their efficiency is measured objectively through appropriate prices for their output, they can be freed from the many bureaucratic controls which have been used to provide a substitute form of discipline. In this new environment management could delegate authority to the lowest level at which revenue, and the costs associated with that revenue, could be measured. Management control in this environment would operate principally through monitoring financial performance and the quality and quantity of what is produced.

We believe this transition would relieve the present management frustrations and unshackle the skills and energies of the many good people in the hospital system. We are confident that if followed through consistently, it would bring about the massive efficiency gains indicated in the Arthur Andersen Report. These gains, if retained in the health services, would allow a 30 to 50 percent increase in output.

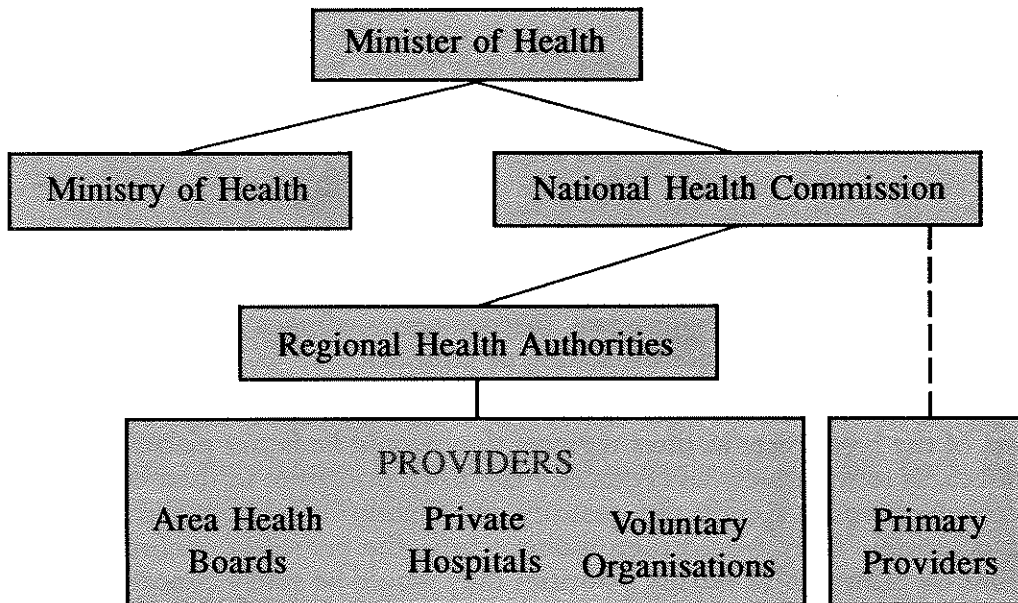
We know of no other way of significantly improving the hospital system without making this transition. We have consulted health economics experts from the United Kingdom, Australia and the United States and all of them agree that no major improvement in our system can be achieved without paying hospitals and other health providers for the specific treatments they provide instead of reimbursing them for what they spend,



as we do at the moment. We believe our recommendations would raise the levels of efficiency, responsiveness and accountability found in hospitals at present, while also improving access and morale.

Inevitably, over time, society's expectations of its state funded health system will change. By releasing the system from its present constraints we believe this structure would give society much greater control of its evolution.

## 5.1 PROPOSED STRUCTURE FOR THE HEALTH SECTOR



### SYSTEM IN BRIEF

The Ministry of Health would deal solely with policy advice to the Minister. The rest of the system would be funded from central government through a newly established National Health Commission, to six Regional Health Authorities on a population basis. The six Regional Health Authorities would purchase publicly funded health services from hospitals and other health providers on behalf of the people in their regions. They would not manage or own any services but would contract with public, private and voluntary providers on a competitively neutral basis.

The existing hospital and area health boards would all become area health boards. These boards would be paid only for the services they provide. Together with providers from the private and voluntary sectors they would compete on equal terms to sell services to the Regional Health Authorities and the ACC.

The National Health Commission would separate operational responsibilities from the policy making responsibilities of the Ministry of Health. This would remove the potential for advice to favour the operational group rather than the interests of consumers and taxpayers as a whole. By clearly delineating their respective responsibilities, it should be possible to assess the performance of each organisation more readily. This separation

would not preclude the National Health Commission from proposing changes to policy or providing information based on its operating experience.

The Regional Health Authorities, unlike the present hospital boards and area health boards, would have responsibility to the consumer only. As patients are not paying for themselves, they need an independent body with power of the purse to look after their interests. At present, hospital and area health boards tend to put the concerns of providers uppermost because they own the hospitals and employ the staff. As we have pointed out already, this creates a conflict of interest for boards when they attempt to represent the consumers' viewpoint. The new Regional Health Authorities would not have these conflicts between the interests of staff and patients.

The introduction of Regional Health Authorities would enable us to pay area health boards and other providers at arm's length, on a competitively neutral basis, according to the value of what they do. In this way hospitals would be unshackled and induced to make the massive efficiency gains that are possible.

Another important function of Regional Health Authorities is to enable a cap or limit to be placed on total public funding. While the efficiency gains we propose would be more than enough to eliminate the waiting lists for services where there are current queuing problems, the incentives in the system would ensure that many more services would be offered by providers. As long as services are 'free' it is certain that demand would ultimately outstrip society's willingness to pay, necessitating a limit on government expenditure. This would require the setting of priorities.

As Regional Health Authorities would be elected and only concerned with the interests of the consumers in their regions, they would be better placed than are the current boards to sensitively and equitably lay down priorities. In their contracts with providers they would specify the quantity and quality of services and the basis for setting priorities. They would then monitor how the providers conformed to their directions on priorities. In setting priorities they would be solely concerned with the consumers' interests and, unlike the boards at present, they would not be worried about the possible inconveniences to staff in changing priorities.

Under our proposal area health boards would become more like the boards of public companies. They would be able to concentrate on running efficient services, helped greatly by the payment system which would give them an objective value of the services they provide. These prices would drive signals through the system, causing rapid improvements in resource use and clinical practice.

## **5.2 DETAILED RESPONSIBILITIES**

The full responsibilities of each of the participants in the new structure are outlined in the following sections.

### **MINISTER OF HEALTH**

Under this structure the Minister would be responsible for policy and the development of the health service. He or she would answer to Parliament for the Ministry and the National Health Commission.

As the choice of services to be provided would become a regional responsibility, the Minister would no longer need to be involved in the myriad of operational details that

confront him or her at present. Decentralisation would enable the Minister to concentrate instead on guiding and overseeing the policy framework for the health system.

The Minister's main functions would be:

**policy responsibility for**

- the level of government expenditure on health
- the choice of procedures that would not be publicly funded
- the level of any user contributions for publicly funded services
- the legislation that affects the organisation of public involvement in health

**appointment powers**

- to appoint health commissioners and to dismiss them for inadequate performance
- to dismiss the board of a Regional Health Authority and appoint a commissioner/s where the Minister considers that this would serve the public interest
- to dismiss the board and chief executive officer of an area health board for poor financial performance or for gross negligence and appoint a commissioner

**instruction powers**

- to instruct the National Health Commission on the use of public funds; any such instructions to be published.

## MINISTRY OF HEALTH

The Minister should have a source of independent advice and a resource to assist him or her in formulating policy. We propose that the Ministry be responsible for this function. A small, tightly knit organisation is envisaged, with no operational or service responsibilities. A broad approach to health would be taken by this unit.

The Ministry's principal functions would be:

- to provide independent policy advice to the Minister and assist in the discharge of his or her functions
- to oversee the development of legislation for health policy.

## NATIONAL HEALTH COMMISSION

The National Health Commission would be an independent statutory body, answerable to Parliament in accordance with its Act. It would consist of three members, appointed by the Minister, two of whom should be chosen for their managerial experience. The Commission would oversee, co-ordinate and assist all the other organisations to develop the structural proposals outlined.

The National Health Commission's main functions would be:

**funding**

- to allocate funds to Regional Health Authorities in accordance with a population based formula it develops, and which is approved by the Minister
- to fund primary health care benefits at rates determined by the Minister and subject to conditions set out by the Minister
- to fund services which cannot be delegated, for example national health protection measures and health promotion campaigns

**monitoring**

- to review and publicly report on Regional Health Authorities' estimates of expenditure and service and strategic plans
- to contract the monitoring, evaluation and public reporting of the financial performance of Regional Health Authorities, their quality of service, the health status of consumers in their regions, and the levels of consumer satisfaction with the services provided
- to report on the overall performance of the health service, and in particular its contribution to health

**powers**

- to seek information from all health organisations to the extent necessary to assess whether Regional Health Authorities are funding services of the best value and of the quality and type preferred by consumers
- to instruct Regional Health Authorities on matters of public health
- to delegate to Regional Health Authorities the administration of primary health care benefits if the National Health Commission chooses
- to commission research or investigations to improve the organisation and quality of the health service

**advisory**

- to provide case-based payment systems, service guidelines and standards of service for voluntary use by Regional Health Authorities
- to disseminate information to consumers on how the health system works, where to complain, how to gain help within the system, how to choose health care wisely

**structural**

- to organise the establishment of a professional review organisation which would monitor the performance of area health boards and other providers under contract to the National Health Commission and Regional Health Authorities.

**REGIONAL HEALTH AUTHORITIES**

Regional Health Authorities would be lean independent elected bodies with small operating budgets and tightly defined duties. They would be solely responsible for buying hospital and related services for the people in their region. They should develop a comprehensive service which would co-ordinate hospital and specialist services and develop appropriate links with the voluntary sector as well as the environmental health

services, in accordance with national guidelines that are adapted to local conditions and the wishes of local communities.

Regional Health Authorities would decide the type and balance of services and the provider organisations best suited to deliver them. Choice would be influenced by their resources, the demographic characteristics of a region, the views of health professionals and more particularly of the people who use the services. In some instances, such as people who are dependent long term, it may be better for health benefits to be paid directly to users, rather than to providers. In this way people could spend their allocation on the services and providers they preferred. In its submission to the Taskforce, the New Zealand Society for the Intellectually Handicapped strongly recommended this option for their members. We also believe it could be appropriate for other long stay groups such as the elderly.

The Regional Health Authorities would be prohibited from providing any health services themselves. The 13 members of the authority would act as representatives of their community, voted to the position through an electoral process. The Regional Health Authority would have the authority to co-opt additional Maori representatives to its board. Local Maori authorities and iwi should nominate any such representatives. Other representatives with particular skills or perspectives could be co-opted as required. To avoid conflicts of interest, we believe representatives and staff of provider organisations funded by the Regional Health Authority, should not be eligible for election or co-option.

The principal functions of a Regional Health Authority as agent for the consumer would be:

#### **buying services**

- to determine the mix, level and standard of hospital, community health and health protection services to be bought in its region with public funds
- to choose neutrally among public, private and voluntary providers of services, on the basis of quality and value for money
- to purchase services on a case-based payment system
- to determine equitable methods of rationing services in short supply

#### **monitoring**

- to monitor the rationing methods of hospitals
- to engage a professional review organisation to audit the contracted services to ascertain whether they were provided according to the agreed specifications
- to monitor and report on the health status of its region

#### **powers**

- to appoint and dismiss a chief executive officer and delegate such powers as the authority sees fit
- to carry forward under or over expenditure within general limits set by the National Health Commission
- to raise bank overdrafts to the limits specified by the National Health Commission.

Geography, service patterns, population and management requirements have led the Taskforce to recommend six Regional Health Authorities for New Zealand. (A full list of these regions and the areas they cover is given in Appendix 3.) Four of these boards would be of roughly equal size (465–574,000 population), the Northern Region including Auckland would be significantly larger with a population of 1,017,000 and the Southern Region would cover a large geographical area containing only 290,000 people.

There are several reasons for recommending six Regional Health Authorities. The main ones are:

**migration:** the effects of population movement on the funding formula need to be smoothed over a reasonably large group;

**comparability:** the regions would be large enough to ensure that each Regional Health Authority would be more comparable in terms of the population served and the likely pattern of services required, including a mix of urban and rural services;

**economies of scale:** each Regional Health Authority needs to be of a sufficient size to afford the specialist technical and managerial skills necessary;

**choice of providers:** to ensure a high degree of responsiveness from providers, it is important that there be a reasonable range of alternatives available in each Regional Health Authority area;

**range of services:** each Regional Health Authority would contain nearly all services required by residents of the region. Analysis of movement of patients across area health and hospital board boundaries has shown that over 90 percent of use would take place within the proposed regions. Thus the choice of six Regional Health Authorities ensures that reasonable access for most services would be provided within each authority's area and would ensure that all Regional Health Authorities have a responsibility to plan and provide a comprehensive range of services.

All the above points argue for Regional Health Authorities of a substantial size. But in order for regions to be as responsive as possible to consumers, they should not be too large or remote. We believe that in recommending six Regional Health Authorities we have balanced these conflicting size requirements.

Various regional groupings have been proposed already and our boundaries attempt to fit these communities of interest. The six hospital boards within the area south of the Waitaki River formed the Southern Region Health Services Association in 1984. Similar groupings of hospital boards in the Waikato and adjacent areas have also expressed interest in banding together.

Unlike the regional and district health areas in England or the regional groups in New South Wales, the Regional Health Authorities and the National Health Commission would have no provider management role and should be slim organisations with small budgets and tightly defined duties. For this reason we consider that no more than two per cent of the health budget should be set aside to fund both the Regional Health Authorities and the National Health Commission.

Although these Regional Health Authorities are expected to have the interests of consumers foremost in their decision-making, they are likely to face difficulties in determining the full range and strength of consumer preferences. Consequently, if the

Government wishes to achieve a health system which is more responsive than that proposed here, it would need to develop some form of consumer based funding.

## PROVIDERS

Providers of health services make up the final level in our structure. At present they include area health boards, hospital boards, voluntary organisations and private institutions. It is important that Regional Health Authorities purchase services from all the agencies, whether public, private or voluntary purely on the basis of value for money to ensure competition in the system. None of the providers—public, private or voluntary—would receive any government funding (other than some primary health care benefits) unless it was for specific services contracted by a Regional Health Authority. In the reforms proposed, area health boards would not be owned by their funder organisation, the Regional Health Authority.

Legislation should set out the responsibilities of hospitals in New Zealand, whether owned by the state (in whole or part) or otherwise. In general the legislation should cover:

- safety aspects
- a register of patients
- records and data sets required, furnishing of information
- inspection rights

This legislation should ensure that the public is protected, but should not allow unreasonable interference or control of hospitals' activities. We strongly recommend that a non-compulsory accreditation programme should be promoted to provide regular and informed comment on broad standards. It would eventually allow people, and those who refer patients, to recognise accredited hospitals as places which meet specified quality standards.

The providers' role would be to produce the services required by consumers who would be represented by the Regional Health Authorities. Instead of receiving a per capita payment as they do now, contracts would be negotiated with Regional Health Authorities for the quantity and quality of services and the price to be paid for them. Public, private and voluntary health care organisations would be free to accept contracts from the Regional Health Authority, the ACC, or from private patients. Providers could also sub-contract amongst themselves: private to public, public to voluntary, or public to private. Once public hospitals are operating on a competitively neutral basis they should be able to treat private patients.

Contracts would not rely solely on tendering. They would usually be negotiated with the providers capable of doing the work. The contract would specify price and the maximum number of services the provider could supply, effectively capping the costs. For practical reasons, some flexibility would be allowed in the contract. From payments for services, area health boards, voluntary organisations and private providers would be expected to cover all their costs and make a profit. From their profits area health boards would purchase equipment, invest in research, and service loans for capital investment. They would operate like any other business and would be free to arrange their affairs and remunerate their staff as they judge best. To ensure competitive neutrality they also would be subject to normal taxation.

We recommend that existing hospital boards should make the transition to area health boards as soon as possible and take over the health services provided to individuals run by the Department of Health, such as immunisation and public health nursing. Other public health monitoring functions, for example water quality control or inspection of premises, would become the responsibility of local authorities. It would be preferable to divide hospital boards which have more than one large hospital into more than one area health board as this will enable Regional Health Authorities to have alternative suppliers. Efficiency will not be prejudiced as we understand that the most appropriate economies of scale for an individual hospital occur between 200 and 450 beds. Hospitals that are either smaller or larger are likely to be relatively inefficient.

The Holmes Committee has already recommended establishing four districts in Auckland. We consider each of these districts should become an area health board. Other areas that could benefit by reducing the monopoly of provider organisations are Wellington, Waikato and Canterbury. We recommend that in each of these cases two area health boards be formed by splitting existing hospital boards. There is also a case for merging some of the smaller boards. Our evaluation of the performance of small boards, and the expanded role area health boards would have under this system, suggests that some adjacent small boards are likely to merge voluntarily under the disciplines of our proposals.

In order to place area health boards on an equal footing to compete with other providers and to allow a more accurate assessment of financial performance, the government would have to set for each area health board while taking account of access considerations:

- the valuation of the assets used
- the required rate of return expected
- the financial reporting requirements.

At present, management accountability in public hospitals and area health boards is affected by the fact that ownership of both is unclear. Nobody has a vested interest in making sure of the long term viability of the "business". As long as there is no clear ownership, there remains a danger that area health boards could subsidise inefficiency by running down their assets. If this happened then the introduction of rewards for performance would not increase efficiency. Instead, area health boards would achieve lower prices by subsidies which would need to be repaid in the future, probably by government.

To increase the accountability of managers in the public sector, we suggest that the ownership of public hospitals needs to be resolved, as is happening now with electrical supply authorities, harbour boards and trustee savings banks. In the interim it may be necessary to make financial loss (a decline in the net worth of the enterprise) grounds for dismissal of a board and its chief executive.

Until ownership is resolved and the owners able to place their chosen directors on the board, we recommend that boards should continue to be elected by popular vote. During this interim period the boards should be given the power to co-opt persons with business management skills. Despite the Taskforce's reservations about elected boards, we believe the disciplines set up in our proposed payment system would act as incentives for better performance. Mismanagement would lead to financial difficulties; and serious mismanagement should result in the dismissal of the board and its chief executive by the Minister of Health or other responsible authority.



### 5.3 ESSENTIAL MECHANISMS IN THE SYSTEM

In the following sections we describe further key mechanisms which would be used in our structural reforms. The first is a method of payment for services performed by contracted providers; the second, a monitoring agency concerned with the choice and quality of all publicly funded health services.

#### PAYMENT SYSTEM

As we have discussed previously, all payments should be related to outputs. The form of payment that comes closest to rewarding performance in the provision of health care is a case-based payment system. A fixed payment is made for all medical services for a given condition during a defined period of care.

This system offers considerable incentives to providers to improve efficiency and increase throughput. All hospital staff—doctors, nurses, hospital administrators and others—would be encouraged to constantly review their operational and management procedures. Unnecessary processes, the duplication of diagnostic tests for instance, would be contained because their cost would come out of a fixed payment. A case-based method of reimbursement would foster a team approach. Instead of controls which pit different units in the institution against each other, the method of payment would become a discipline that encouraged the co-operation of all staff to ensure that their unit and the whole institution prospered. It would also ensure that management teams scrutinised professional services and their costs.

The best known and tested case-based system is the diagnosis related group (DRG). DRG is the name given to a method of classifying different illnesses according to their similarity and expected pattern of resource use in hospital treatment and care. DRGs are essentially a way of describing hospital output.

The United States has implemented this classification system to reimburse hospitals in the government funded Medicare programme (for the elderly) on a national basis, and Medicaid (for the poor) in some states. Payment is based on a set fee for a specific service. Hospitals using a DRG system are reimbursed for treatment of a disease or illness on the basis of a payment fixed in advance, rather than retrospectively. The rate used for each DRG is derived from average costs. Thus poor performers are constantly pressured to reduce their costs to the average. This in turn lowers the average cost, until all hospitals have similar levels of efficiency. Current research by the New Zealand National Health Statistics Centre suggests that the United States classification system is likely to be appropriate for New Zealand diagnoses of acute illnesses. However, much further work and careful testing needs to be done to apply DRGs to New Zealand conditions.

A major issue in operating a case-based payment system is how to determine the payment levels. There are several possibilities:

- to take an average of the existing costs for each set of services, as applies in the United States;
- to apply representative prices to standard practices to generate an estimate;
- to relate the payment to the costs of the most efficient provider;
- to set the payment through individual negotiation;
- to let the payment be determined through market forces, for example by competitive bidding.

During the early years of the use of DRGs we would expect that the Regional Health Authorities would need to award contracts based on a mixture of these approaches. As costing systems develop and management practices improve, it should be possible to move to rates based on best practice and test them through competitive bidding. While regional health services should retain some flexibility in setting payment rates, there are considerable advantages in aiming for a common price for hospitals across as much of the country as possible. It would give individual hospitals powerful incentives to work towards a common standard of economic efficiency.

In recommending the early introduction of case-based payments, we are fully aware that a DRG system is not without shortcomings. The two major criticisms of the United States DRG system are its potential to encourage both over-servicing on a national basis and under-servicing at an individual level.

To counter the potential to encourage over-servicing, we propose capping total hospital spending through the budgets allocated to the Regional Health Authorities. The Regional Health Authorities would identify the range and quantity of services they require for their community. Then, in allocating funds to a particular provider, the two parties would come to an agreement on the type, number and quality of services the Regional Health Authority expects that provider to supply and the level of payment. The system of allocating priorities between consumers would also be laid down by the Regional Health Authority.

To counter the incentives to reduce or defer medically necessary services within each DRG, and to avoid the complex cases, Regional Health Authorities would need to closely monitor the quality of care. Since this is a highly specialised activity, we would recommend the formation of professional review organisations which would work under contract to the National Health Commission and the Regional Health Authorities. (Professional review organisations are described in the next section.) Extending the current 467 DRG categories to include ambulatory and rehabilitative care, and devising a standard rate of payment to cover chronic, long stay, fluctuating and multiple diagnosis conditions, should also reduce the incentives to under-serve and pass on costs and responsibility to other areas, particularly community care and social welfare.

## PROFESSIONAL REVIEW ORGANISATIONS

One of the first responsibilities of the National Health Commission would be to establish the initial professional review organisation. This professional review organisation would be an independent agency contracted by the National Health Commission and the Regional Health Authorities to ensure that their health policies, and the conditions stipulated in negotiations with public, private and voluntary providers, were being adhered to, within reasonable clinical bounds. Over time, a number of professional review organisations are likely to develop.

The most powerful influence of professional review organisations is on clinical behaviour. They would be major contributors to the control of the quality of services provided, and the protectors of the individual user of the health system, guarding against under-treatment—being discharged too early, and over-treatment—the use of unnecessarily complicated treatment procedures.

The work of independent professional review organisations would be a crucial discipline in the structure we propose. They would be multi-disciplinary in character and include

consumer interests. We also consider it essential that all the work undertaken by a professional review organisation and its subsequent findings should be published, subject to patient confidentiality requirements, and open to criticism from everyone else within the system. In that way an equal discipline is placed on the activities of the professional review organisation itself.

## 5.4 RELATED ISSUES

The final sections of this chapter deal with issues which, although not directly addressed in our proposed reforms, need to be considered in relation to the changes. One is the interaction between secondary and primary care. Others concern the role of education and research in the hospital system.

### PRIMARY HEALTH CARE

The inadequacies of the existing primary health benefits system have been well documented, most recently by the Health Benefits Review. However, the formation of Regional Health Authorities, and the other reforms proposed for the hospital sector, would require considerable attention for their implementation in the time frame envisaged. We recommend that once the Regional Health Authorities and different provider groups have become used to their roles and are functioning effectively, there be a review to determine the best way to interrelate with primary care.

It is expected that as Regional Health Authorities realise the potential of increased cooperation with primary providers, particularly the importance of the general practitioner's role as gate-keeper in keeping down costs in the secondary sector, they will look for ways of involving primary sector practitioners.

### EDUCATION

There are a number of problems in funding and administering the education of health professionals in the hospital system. At present two groups, hospital and area health boards and the technical institutes and universities, are involved in complex contractual and ad hoc arrangements. Various professional organisations have also developed other arrangements which all involve the resources of the health system, but more especially of the public hospital sector. The inter-connection between education and research is a further complication.

This current system has its strengths and weaknesses but, on balance, it has led to conflict and the shirking of responsibilities by both tertiary institutes and hospital administrations. The effect has been detrimental to morale. This situation and its consequences must be addressed in terms of our proposals for the future development of the hospital system. Any scheme must provide teaching programmes as well as creating an environment which sustains staff morale, encourages initiative and increases management's capacity to run efficient services. In simple terms, the educational functions of the health service are the acquisition of basic qualifications by present and future staff (nurses, doctors, physiotherapists, and others) and continuing education and retraining.

We believe that the acquisition of basic qualifications should be consistent with the policy for other tertiary education. At present, those taking basic degrees and diplomas pay lecture and tuition fees, receive bursaries and are generally responsible for their own living

expenses. However, there are two possible means of funding the additional service costs of the basic teaching role in hospitals.

The first is similar to the present system. The Regional Health Authorities would need to ensure that their approved prices were sufficient to cover the cost of providing work experience for basic qualification trainees. The bonus to the public, private and voluntary providers involved would be the raised standard of morale associated with the education of young people. Any service increment for teaching might well be included in the population based funding formula to regions, a concept acknowledged in the present formula.

In this approach to training there is no clear distinction made between 'educational activities' and 'service activities'. Therefore, it would give teaching hospitals no indication of the relative funding emphases to be made between teaching and treatment services. It would be possible for those hospitals to cross-subsidise hospital services from their teaching funds. Regional health authorities would find it difficult to monitor the quality of educational services since they would not be primarily responsible for funding the overall training. The very limited number of teaching institutions in any Regional Health Authority area, and lack of comparative information as a consequence, would increase the complexity of the Authority's negotiations. So too would the difficulties in comparing the cost structures of the service work of teaching hospitals with that of non-teaching hospitals. Furthermore, in monitoring the performance of providers Regional Health Authorities would have to weigh up any deficiencies in the performance of teaching services compared with hospital services.

The second method for taking account of basic teaching costs in hospitals is also compatible with our overall proposals. The additional service costs incurred in basic training would be allocated through Vote:Education. These funds would be paid by technical institutes and universities to providers contracted to give service experience. The agreed payment would cover the cost of acquiring the staff and clinical situations required for teaching purposes.

In this approach, the organisation primarily responsible for teaching would fund all aspects of that activity directly. This would have the advantage of making quite clear where the emphasis would be placed. The education authorities would deal with all teaching institutes nationwide, giving them a better information base on which to negotiate payments. The clear focus of each funding agency—health and education—would ensure that due weight could be given to each of the two functions when their outputs were evaluated.

The major disadvantages of this method are the potential for disagreement between funders (educational and health service) and providers over which costs belong to 'education' and which to 'health'; and the identification of educational activities as being quite separate from the staff's health service work. Both these situations could create disharmony. For the same reasons, though, costs would be more visible and therefore the activities of all hospitals could be better compared.

We have no major objection to either method being used.

The provision of continuing education, retraining, refresher and conference leave for all levels of staff, be they secretarial, technical or clinical, must be an accepted part of the public, voluntary and private sectors' ordinary expenditure. Past and present experience suggests that not all boards have recognised the contribution that training can make to performance. The costs of continuing education should be part of the overheads included in price contracts between the Regional Health Authorities and providers. We highlight

this rather obvious point simply because continuing education is a low priority for some area health and hospital boards at present. A welcome sign of change would be a separate cost heading for such expenditure in every cost centre's budget.

We would certainly recommend that reviews of provider practice and service quality by any hospital accrediting body and professional review organisations should include providers' activities in basic and continuing education.

## RESEARCH

New Zealand has a high reputation in some fields for the quality of research undertaken within its university, health, education and service systems. It is extremely important that the kind of environment needed to foster this initiative and work is maintained if our future health services are to be able to recruit and retain people of high calibre.

In every country the highest standards of health care are found in environments which incorporate strong research components. Such environments must allow for research which does not have any direct benefits for the institutions in which it takes place. Such work (called nonappropriable research) is unlikely to be funded by management. Secondly, a sound health service needs the capacity to undertake and commission research and development of technologies and techniques which do show clear benefits by improving the efficiency of organisations.

It would seem appropriate for the Medical Research Council (or its successor following the recently announced review) to continue as a primary source of resource for 'nonappropriable' research. There would be no prohibition on research being done within the health system, or on the use of health funds for that purpose. However, such costs would need to be balanced against obligations to provide an adequate range of efficient services. It is an area in the activities of Regional Health Authorities and providers which the professional review organisations and National Health Commission would monitor and comment on regularly.

# CHAPTER 6

## IMPLEMENTATION

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The scope of the proposals outlined in this report is deceptive. Although we have based our reforms on existing systems, much detailed work is necessary. Major effort would precede the introduction of new organisations, such as a National Health Commission, Regional Health Authorities and a professional review organisation, and the reorganisation of existing hospital boards and area health boards to meet the requirements of the new environment. The changes, moreover, would occur in a service not characterised by strong management, nor known for its speed of action.

### 6.1 CURRENT INITIATIVES

Fortunately, a great deal of study relevant to our proposals is already under way, but the work would need to be intensified.

#### UNITY OF COMMAND

General managers rather than triumvirates should be adopted widely in the health service. It would provide clear accountability, develop leadership and give a single point of reference for strategic planning, setting objectives, decision-making, action and information.

A training programme for 'general managers' has already been established by the Department of Health. Its need has been reinforced by the introduction of the State Sector Bill. The changes to organisation required by general management create an immense requirement for improved managerial and other systems, and the training and up-grading of management staff at all levels.

#### MANAGEMENT INFORMATION SYSTEMS

The early part of this report drew attention to the appalling absence of relevant management information and costings throughout the present system. This must be remedied quickly. The information will be essential to the management of area health boards.

Pilot studies in performance indicators and clinical budgeting are already under way at the Waikato and Otago Hospital Boards and should be extended as quickly as possible to all boards. A lot of time has been spent on how health service information is processed. It is more important now that attention is given to what data sets are required nationally by managers in the service. The information should enable comparisons to be made between services, hospitals, boards and Regional Health Authorities.

#### CAPITAL FUNDING

The Department of Health is working to include capital funding in the population based grant. We recommend that this inclusion takes effect from 1 April 1989. Boards would need to establish depreciation funds and some initial smoothing of the effects of existing or approved large capital projects may be necessary.

We recommend that on 1 April 1989 the Government reconstructs the balance sheets and debt of boards and from that date boards be permitted to raise loans/mortgages commercially, without government guarantee. This last condition is necessary to ensure that boards are not absolved from poor capital and investment decisions. Further unshackling would occur from that date if all capital projects no longer required the approval of the Minister. Any short term financial difficulties would be outweighed by the end of delays and the 'lottery' for loan fund approvals.

The obvious discipline on boards would be that their treatment cost structure would be excessive if they over-invest in capital.

## **DIAGNOSIS RELATED GROUPS**

Work on diagnosis related groups (DRGs) has already begun as part of a study on cross boundary flows. The International Classification of Diseases (ICD) code now used in New Zealand for patient diagnosis is compatible with overseas systems using or developing DRGs. As such a powerful method of payment would clearly be preferred in any system paying for services, an intensive review of existing systems and cost studies should begin to develop a system which can be used within New Zealand. We suggest that, initially, managers would need to learn how to use this information to guide their decisions. By staggering its implementation over three years, they could gain the necessary experience before moving to a system operated entirely on a DRG payment basis.

## **QUALITY CONTROL**

Although the statutory agent currently responsible for quality control (the Department of Health) has taken a rather relaxed line to date, it has commenced some activity in this area. At least one hospital board (Waikato) has established a board level committee whose brief includes quality assurance. All boards and every treatment facility should have such a committee. A pilot project has also begun on accreditation of hospitals.

We believe the Department of Health should take immediate steps to establish a professional review organisation, in embryo at least, while also helping to develop quality assurance projects. Once the National Health Commission is established, it could begin more specialised training and development of the professional review organisations.

## **GOVERNMENT AND OTHER REVIEWS**

There are a large number of government and other reviews proceeding at present which will affect our proposals to varying degrees. We comment only on those we believe relevant.

### **The State Sector Bill**

The Bill was before a select committee as we finalised our report. We would advocate that area health boards should be able to negotiate their own industrial awards and conditions of employment. It would be helpful, however, if the boards were given some assistance by the State Services Commission and/or the National Health Commission, until they are ready for their new role.

## **Royal Commission on Social Policy**

Major recommendations on the future framework of social policy are expected from the Royal Commission. Our framework provides a sound basis for the implementation of almost any approach.

## **Health : Social Welfare Boundaries**

A number of reviews are underway which may affect health and social welfare policies. We believe there needs to be urgent action on the boundaries between social welfare and health. The highest priority is in the chaotic area of long stay care.

The need to determine whether long stay expenses are an income maintenance or health problem is extremely important. As hospitals become more efficient, pressure of some form or another will be placed on social welfare. The Department of Social Welfare is aggrieved at the apparent lack of cooperation from the health sector in the arrangements for discharge of intellectually handicapped people from hospitals. Leaving policy issues unresolved could frustrate attempts to improve equity in health care as well as efficiency. Clear policies are required.

## **Accident Compensation Corporation**

We are confident that any decisions made by Government on the Accident Compensation Corporation would be compatible with our proposed structure. We believe that if the Accident Compensation Corporation continues to fund health care, it should pay for its patients' treatment whoever the provider. Regional Health Authorities should not pay for Accident Compensation Corporation treatments.

## **Local and Regional Government**

The review of local and regional government could have relevance for the health service. Some links already exist at local level for planning purposes. Our proposal has not envisaged major changes beyond the transfer of some health department functions to local authorities. Our system allows for possible recommendations from these reviews to be incorporated with minimum disruption.

## **6.2 TIMETABLE FOR IMPLEMENTATION**

### **Year 1 — April 1988 to March 1989**

- |                  |  |
|------------------|--|
| April 1988       | — Department of Health intensifies development of DRGs   |
| by December 1988 | — all existing hospital boards become area health boards   |
|                  | — valuation of assets to commence  |
|                  | — current funding systems to continue  |
| by March 1989    | — necessary legislation to be in place   |
|                  | — transfer specified public health functions to local authorities  |
|                  | — development staff appointed within the Department of Health and the initial draft of National Health Commission policies, monitoring systems, DRGs and other methods of payment for output developed |



— appointment of interim chief executive for National Health Commission

## **Year 2 — April 1989 to March 1990**

- by April 1989
- boards' current loan debt rationalised and a commercial structure set up
  - removal of government guarantees for boards' future commitments
  - funds including capital allocated on a per capita basis to area health boards
  - start using interim DRGs to judge the implications of case payments
- by June 1989
- set up administration of the new area health boards in Auckland, Wellington, Canterbury and Waikato
  - National Health Commission commissioners appointed and establishment finalised
  - professional review organisations established and detailed training begun
  - staff and interim chief executive officers for Regional Health Authorities appointed and operating systems started
- by October 1989
- Department of Health becomes Ministry of Health and is restructured to fit its new status
  - boards of Regional Health Authorities elected
  - boards of area health boards elected, including new area health boards in Auckland, Wellington, Canterbury and Waikato

## **Year 3 — April 1990 to March 1991**

- by April 1990
- National Health Commission to allocate funds to Regional Health Authorities according to its new approved formula
  - Regional Health Authorities to fund area health boards approx 75 percent on the current basis and 25 percent DRGs and 'standard rates of payment' for services
  - allow Regional Health Authorities to contract with other providers
  - professional review organisations contracted by National Health Commission and all Regional Health Authorities to monitor services; to be fully functional by March 1991

## **Year 4 — April 1991 to March 1992**

- by April 1991
- Regional Health Authorities to fund area health boards approx 50 percent on current basis and 50 percent DRGs and 'standard rates of payment' for services

UNSHACKLING THE HOSPITALS

**Year 5 — April 1992 to March 1993**

by April 1992

— the whole system fully operational; Regional Health Authorities to fund area health boards and private and voluntary agencies solely on DRGs and standard rates of payment for services.

## APPENDIX 1

### WAITING TIMES FOR SURGICAL OUT-PATIENTS

Table 1: Waiting times for a non-urgent appointment in surgical clinics (time in weeks)

Board	Orthopaedic	ENT Surg	Ophthalmology	Gynaecology	Urology	General Surg	Plastic Surg	Dental Surg	Cardiothoracic	Neurosurg
Northland	8-26	13-52	13-34	2-8	26	0-11	8	4	-	-
Auckland	4-104	2-78	4-43	4-52	2-17	1-6	1-17	0-3	0-2	1-4
Thames	21	-	4	4	2	9	-	-	-	-
Waikato	2-26	17-26	30-52	4-39	4-21	..	13	1-4	-	3-17
Tauranga	9-13	21-26	21-26	17	9-13	26-30	-	-	-	-
Bay of Plenty	6	6	-	3	52	1-3	-	-	-	-
Taumarunui	0-4	0-13(2)	0-8	0-4	0-4	0-4	-	0-4	-	-
Cook	34	8	8	13	30	13	30	-	30	30
Taranaki	4-5	8-13	13-26	6-8	3-4	4-13	0-13(2)	8	-	0-8
Wanganui	7-36	32	-	7-12	-	6-15	-	3	-	-
Hawkes Bay	1-9	1-8	*	4-16	0-8	0-8	-	-	-	-
C Hawkes Bay	9-13	13	-	2-4	2-4	0-1	-	-	-	-
Palmerston North	42	13-26	21	10-104	104	8-17	9	2	-	4
Wairarapa	9	52	14	7	*	4	-	-	-	8
Wellington	8-18	8-36	16-20	4-16	8-13	2-13	13-16	1-8	4	4
Nelson	8	17-22	35	26	3	3	4-13	2	-	-
Marlborough	14-52	52	22	6	10	13	10	*	-	0
West Coast	3-4	0-13(3)	0-30	0	0-17(3)	..	0-17(3)	-	-	-
Canterbury	5	34	34	13	13	3	4	1	3	6
Ashburton	26	17	17	-	13	..	-	-	-	-
Southland	4-9	13	4-17	8-17	8	4-9	13	1	4	4
South Otago	4	-	-	2	2	1	-	-	-	4
Otago	1	0-13	17-22	0-8	6-8	4	-	..	7	0-13
Waitaki	4-8(1)	13(1)	0-4	0	0	..	-	1-2	0-4	0-4
RANGE	0-104	0-78	0-43	0-104	0-104	0-30	0-30	0-8	0-30	0-30

#### Notes:

— denotes this service not offered

\* denotes no out-patient clinic

.. denotes data not available

(1) Monthly clinics staffed by Otago Hospital Board staff; surgery in Dunedin Hospital

(2) Clinics every three months

(3) Services staffed by Canterbury Hospital Board staff

These are waiting times for routine appointments; arrangements for urgent appointments can usually be made at short notice. A range has been provided by some boards as out-patient clinics may be held in several hospitals. Where a patient will only see a consultant of their own choice (or their general practitioner's choice) the delay is inevitably much longer. This information is not routinely collected and most boards do not regularly monitor these waiting times. Waipapu, Dannevirke, South Canterbury, Vincent and Maniototo made no returns.

Source: This information was provided by boards and shows waiting times as at December 1987.

## APPENDIX 2 HEALTH CARE EXPENDITURE

Table 1 : Preliminary estimates for year ending 31 March 1987 : \$(000)

Expenditure	Source of Funding						Total Funding
	Vote:Health	Other Government Departments	City Councils	ACC	Charitable Organisation	Households And Individuals	
Public Institutions	2,030,745	55,280		635	4		2,086,664
Private Institutions	108,119			20,317	1,819	66,186	196,441
<b>Institutional Care</b>	<b>2,138,864</b>	<b>55,280</b>		<b>20,952</b>	<b>1,823</b>	<b>66,186</b>	<b>2,283,105</b>
GP Services	92,842	1,670		37,045		146,590	278,147
Specialist Services	64,156	2,696		41,348	7	95,163	203,370
Dental Services	43,230	176		5,207		86,440	135,053
Medicaments	441,962	166		1,240	94	90,169	533,631
<b>Community Medical Care</b>	<b>642,190</b>	<b>4,708</b>		<b>84,840</b>	<b>101</b>	<b>418,362</b>	<b>1,150,201</b>
Public Health	98,179	31,189	9,551		6,738	185	145,842
Teaching	27,460	29,680			1,733		58,873
Research	13,676	12,720			5,474		31,870
<b>TOTAL HEALTH CARE</b>	<b>2,920,369</b>	<b>133,577</b>	<b>9,551</b>	<b>105,792</b>	<b>15,869</b>	<b>484,733</b>	<b>3,669,891</b>
<b>Total Health Care % of GDP</b>	<b>5.52</b>	<b>0.25</b>	<b>0.02</b>	<b>0.20</b>	<b>0.03</b>	<b>0.92</b>	<b>6.94</b>

Notes: GDP \$(million) = 52,879. N.Z. Department of Statistics. Monthly Abstract.

Source: Data compiled for the Taskforce by the Department of Health and private consultants.

## APPENDIX 3 PROPOSED REGIONS

In the new structure recommended for the secondary health sector, six Regional Health Authorities are proposed, four based in the North Island and two in the South Island (see Figure 1). They represent major population and geographical groupings. Four of these boards would be roughly equal in size (465-574,000 population) with the Northern region, including Auckland, significantly larger (population 1,017,000) and the Southern region covering a large geographical area containing only 290,000 people (see Table 1).

Figure 1: Proposed Regional Health Authority Boundaries.

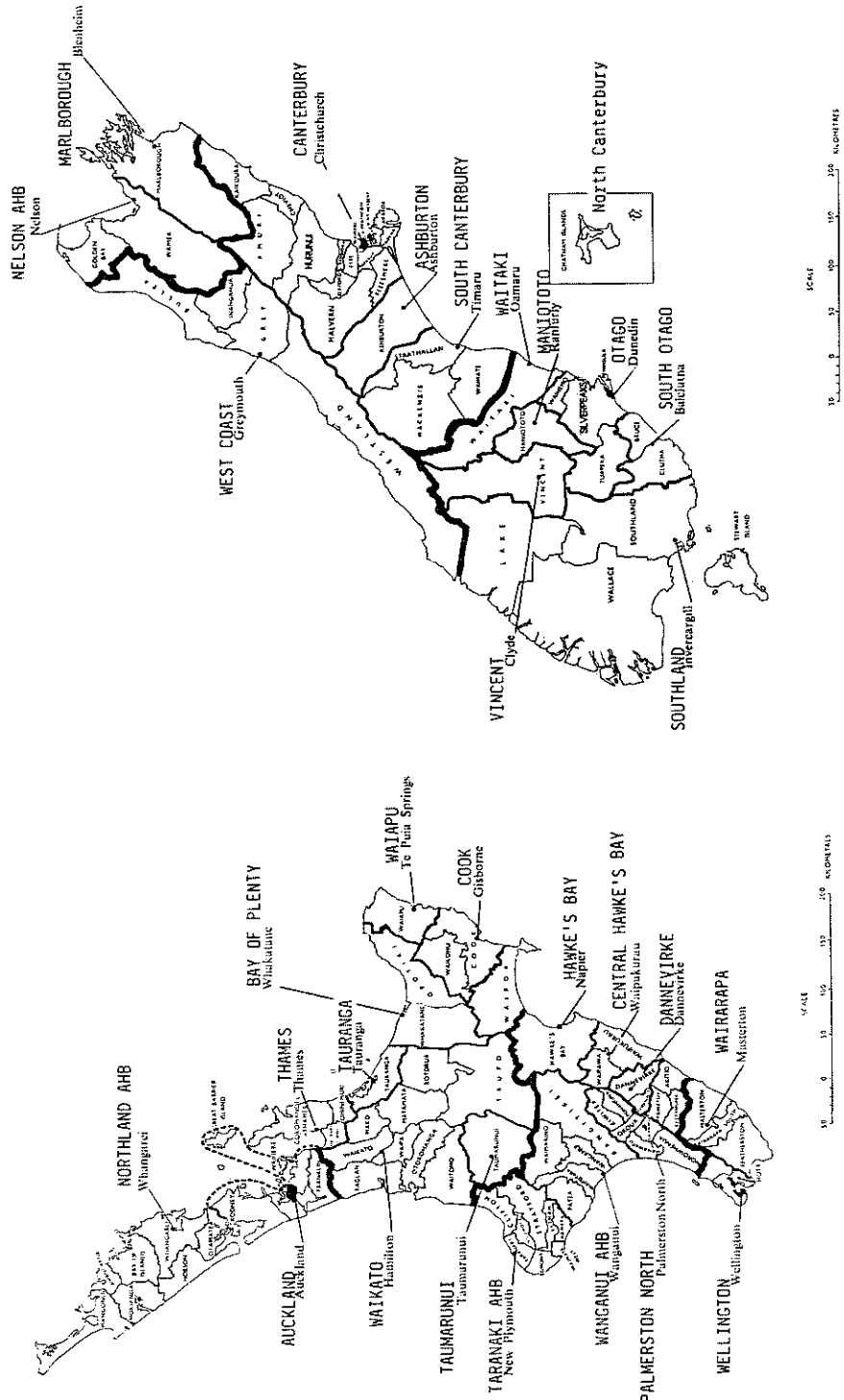


Table 1 : Proposed Regions

Region	Boards	Constituent Districts	Population	Available Beds
1	Northland	13	127,800	827
	Auckland (i)	32	889,100	4,508
	Sub-total	45	1,016,900	5,335
2	Waikato (ii)	21	340,200	2,608
	Taumarunui	2	12,350	123
	Tauranga	5	87,300	418
	Thames	6	40,400	303
	Bay of Plenty	4	47,800	257
	Waiaapu	1	4,580	44
	Cook	3	41,000	313
	Sub-total	42	573,630	4,066
3	Taranaki	14	103,400	651
	Wanganui	12	74,000	745
	Hawkes Bay	6	127,800	776
	Central Hawkes Bay	2	13,200	174
	Dannevirke	4	13,050	137
	Palmerston North	11	134,700	1,534
	Northern Wairarapa	5	29,140	227
	Sub-total	55	495,290	4,244
4	Wellington (ii)	9	344,800	2,550
	Southern Wairarapa	6	15,130	77
	Nelson	5	70,500	976
	Marlborough	3	34,400	209
	Sub-total	22	464,830	3,812
5	West Coast	8	35,100	677
	Canterbury (ii)	21	353,400	3,118
	Ashburton	2	24,800	228
	South Canterbury	7	55,900	494
	Sub-total	38	469,200	4,517
6	Southland	12	115,900	722
	South Otago	5	15,400	149
	Otago	11	121,400	1,337
	Vincent	3	13,650	74
	Maniototo	2	2,320	46
	Waitaki	2	21,400	186
	Sub-total	35	290,070	2,514

## Notes:

(i) To become 4 area health boards

(ii) To become 2 area health boards

Individual boards or districts in boards may have a preference for inclusion in a different region than that described above. These regions are only an indication of the suggested groupings which could make up the six regions.

Source: Data for districts, populations and available beds from Hospital Management Data Year ending March 1987, National Health Statistics Centre.

## APPENDIX 4 CONSULTATION

### 1. CONSULTANTS TO THE TASKFORCE ON HOSPITAL AND RELATED SERVICES

Professor Tony Culyer, Health Economist, York University  
Dr John Deeble, Special Advisor, Commonwealth Department of Health, Canberra  
Dr John Goodman, President, National Centre for Policy Analysis, Dallas  
Dr David Green, Director, Health Policy, Institute of Economic Affairs, London  
Professor Harold Luft, Institute for Health Policy Studies, California  
Dr Walter McNerney, Professor of Hospital and Health Services Management, Northwestern University, Illinois  
Lloyd Morgan, Arthur Andersen and Company, Chicago  
Shirley Valentine, Arthur Andersen and Company, Chicago  
Advisory staff from the Prime Minister's Department and the Minister of Finance's Office  
Senior staff from the Department of Health and The Treasury

### 2. ORGANISATIONS AND INDIVIDUALS CONSULTED BY THE TASKFORCE ON HOSPITAL AND RELATED SERVICES

Accident Compensation Corporation  
Ashburton Hospital Board—members and executive  
Auckland Hospital and School of Medicine—community medicine staff and other interested staff  
Auckland Hospital Board—executive officers, divisions of medicine  
Braemar Hospital—associated community staff  
Bunkle, Phillida  
Canterbury Hospital Board—executive officers, clinical staff and academic staff of Christchurch Clinical School of Medicine  
Cherry Farm Hospital and Hulme House—staff  
Chief Executives' Association—annual conference, Tauranga  
Chief Nurses' Association  
Conference on Ethics of Health Resource Allocation—delegates from Newcastle, New South Wales  
Community Systems Foundation, Sydney  
Committee to Review the Organisation of Health and Hospital Services in Auckland—representatives  
Combined Medical Conference, New Zealand College of Community Medicine and Royal Australian College of Medical Administrators, Auckland  
Cooper, Michael (Professor), Chairman, Otago Hospital Board  
Deane, Rod (Dr)  
Donovan, J (Dr), Department of Health, Canberra  
Duckett, Stephen (Dr), Health Department, Victoria  
Garlick, Glen, Waikato Hospital Board  
Health Benefits Review Committee—Dr Claudia Scott, Geoff Fougere and Dr John Marwick  
Health Service Personnel Commission—Chief Executive and Chairman  
Hospital Boards' Association of New Zealand  
Kawakawa Hospital—executive officers and staff  
Kew Hospital—clinical, administrative and other staff  
Malcolm, Lawrence (Professor), Department of Community Medicine, Wellington Clinical School  
Marshall, Roy, Fremantle Hospital, Perth  
Medical Workforce Planning Committee  
Ministry of Women's Affairs  
National Council of Women  
National Steering Committee of the Combined Health Employees Committee (CHEC)  
Nelson Area Health Board—executive, staff and combined unions  
New Zealand Board of Health  
New Zealand Board of Health Standing Committee on Allocation and Organisation  
New Zealand Board of Health Standing Committee on Hospital and Specialist Services  
New Zealand Institute of Health Administrators—annual conference, Tauranga  
New Zealand Medical Association (North Shore)  
New Zealand Medical Association—executive  
New Zealand Nurses' Association—executive and headquarters staff

New Zealand Resident Medical Officers' Association—conference, Tauranga  
New Zealand Society for the Intellectually Handicapped  
Northland Area Health Board—Chairman and executive staff  
Nurse Administrators' Group of the Nurses' Association  
Nurse Administrators' Group of the Nurses' Association (Auckland)  
Otago Clerical Workers' Union—Hospital Section  
Otago Hospital Board—executive and senior staff  
Pannett, John, Southland Hospital Board  
Pennington, David (Professor), University of Melbourne  
Porirua Hospital—executives  
Rennie, John, Wellington Hospital Board  
Royal Commission on Social Policy  
Royal New Zealand College of General Practitioners  
Short, Doug (Dr), Nelson Hospital  
Simpson, Anne (Dr), Kew Hospital  
South Canterbury Hospital Board—Chairperson, Deputy Chairperson and executive staff  
Southern Cross Medical Care Society—David Turner  
Southern Region Health Services Association—Director and planning unit  
Southland Hospital Board—members and executive  
The Health Alternatives for Women (THAW)  
Travenol Laboratories (New Zealand) Limited—Ned Lipes  
Wanganui Area Health Board—executive, sections of staff and combined unions  
West Auckland Women's Health Collective  
West Coast Hospital Board—executive and senior staff

### 3. SUBMISSIONS AND REPORTS TO THE TASKFORCE ON HOSPITAL AND RELATED SERVICES

Accident Compensation Corporation  
Aldis, D E  
Anderson, M E  
Ashburton Hospital Board  
Auckland Hospital  
    Department of Medical Physics and Bio-engineering  
    Hayes, A—Radiographer  
    McKenzie, A R—Orthopaedic Department  
    Physiotherapists—Neurology Section  
Auckland Hospital Board  
    Brown, R E—Executive Manager, Works  
    Burke, K—Senior Social Worker  
    Charge Physiotherapists' Committee  
    Executive staff  
    Hewitt, A (Dr)—Radiologist  
    Maori Social Workers  
    Mooney, O G—Treasurer  
    Social Workers  
    Tucker, W N—Otolaryngologist  
Australasian College of Physical Scientists in Medicine (New Zealand)  
Australia and New Zealand Myalgic Encephalomyelitis Society Incorporated  
Baird, M A H (Dr)  
Bay of Plenty Hospital Board  
Beasley, D M G—Northland Area Health Board  
Beaven, D W (Professor)  
Bruce, R S—Nelson Base Hospital  
Burke, K  
Burry, A F—Pathologist  
Burwood Hospital—W L F Utey  
Canterbury Hospital Board  
    Darby, M M—Chief Nurse  
    Fairgray, R A (Dr)—Medical Superintendent-in-Chief  
    Herman, D B—Director of Finance



Watson, M—Deputy Chief Executive  
 Canterbury Practice Nurses' Association  
 Carrington Hospital  
     Radcliffe, J L (Dr)—Hospital Management Group  
     Wareing, C (Dr)—Psychiatrist  
 Chief Executives' Association of New Zealand  
 Chief Nurses of New Zealand  
 Christchurch Clinical School of Medicine  
     Clarke, A M (Professor)  
     Gibbs, J M (Professor)  
     Gillespie, W J (Professor)  
     Hornblow, A (Professor)  
     Macbeth, W A A G (Professor)  
     Shannon, F T (Professor)  
 Christchurch Hospital  
     Andrews, D A (Dr)—Medical Superintendent  
     Beard, M E J (Dr)—Haematologist  
     Davidson, J R M—Paediatric Surgeon  
     Gibson, R D—Chairman of Radiology Services  
     Laurenson, V G (Dr)—Anaesthetist  
 Christchurch Women's Hospital  
     McCrostie, H H  
 Clark, M  
 Commandeur, P  
 Contract Negotiation Service  
 Cook Hospital Board  
 Cooper, M (Dr)  
 Crawford, J W  
 Croot, L  
 Department of Health  
     Health Economics Consultative Group  
     Maori Health Project Group  
     Programme Managers  
     Science Unit Directors  
 Dietitians Board  
 Ding, L (Dr)  
 Dryburgh, P R D—Kaitaia Hospital  
 East Cape United Council  
 Epersen, A C  
 Eyes, C  
 Foundation for the Healing Arts  
 Gow, P J (Dr)—Consultant Rheumatologist  
 Gowland, S (Dr)  
 Gudex, R G (Dr)  
 Hawkes Bay Hospital Board—Medical Superintendent-in-Chief  
 Health Service Personnel Commission  
 Heslop, J H (Dr)  
 Hewitt, E A (Dr)  
 Hewland, R (Dr)—Consultant Psychiatrist  
 Hobbs, P (Dr)  
 Hooker, C H  
 Hornibrook, J—Wellington Hospital  
 Horowhenua Hospital  
 Hospice New Zealand Incorporated  
 Hospital Boards' Association of New Zealand (Incorporated)  
 James, M, and Feltham, C (Drs)—X-Ray Centre, Nelson  
 Kaye, B A (Dr)  
 Kydd, D—Taumarunui Hospital Board  
 Maclaurin, B P  
 Marlborough Hospital Board

## UNSHACKLING THE HOSPITALS

Board members  
Halliday, H E—Chief Executive  
Massey University—Department of Nursing Studies  
Medical Council of New Zealand  
Middlemore Hospital  
Gray, D H (Professor)  
Social Work Department  
J Wilson—Rehabilitation Committee  
Ministry of Women's Affairs  
Nelson Area Health Board  
Food Service Department  
Chief and Principal Nurses  
Nelson Bays United Council  
Nelson City Council  
Nelson Provincial Arts Council  
Nelson Women's Health Group  
New Zealand Accreditation Programme for Quality Assurance and Laboratory Testing (TELARC)  
New Zealand Association of Clinical Biochemists  
New Zealand Association of Social Workers Incorporated  
New Zealand Board of Health Standing Committee on Women's Health  
New Zealand College of Community Medicine  
New Zealand Council of Christian Social Services  
New Zealand Dietetic Association Incorporated  
New Zealand Electrical, Electronics and Related Trades Union of Workers (Nelson/Marlborough)  
New Zealand Federated Hotel, Hospital, Restaurant and Related Trades Employees' Industrial Association of Workers  
New Zealand Health Records Association Incorporated  
New Zealand Hospital Boards' Dental Surgeons' Association  
New Zealand Institute of Medical Laboratory Technology Incorporated  
New Zealand Licensed Rest Homes' Association Incorporated  
New Zealand Medical Association  
New Zealand Medical Association, Auckland Division  
New Zealand Nurses' Association Incorporated  
New Zealand Occupational Health Nurses' Association Incorporated  
New Zealand Orthopaedic Association  
New Zealand Private Hospitals' Association Incorporated  
New Zealand Public Service Association Incorporated  
New Zealand Register of Osteopaths Incorporated  
New Zealand Resident Medical Officers' Association  
New Zealand Society of Pathologists Incorporated  
New Zealand Society of Physiotherapists Incorporated  
New Zealand Society of Physiotherapists Incorporated (Nelson)  
New Zealand Society of Radiographers and Medical Radiation Technologists Incorporated  
Ngawhatu Hospital  
North Shore Emergency Medical Services Limited (in conjunction with the North Shore Division of the New Zealand Medical Association)  
Nurses' Society of New Zealand  
Ophthalmological Society of New Zealand  
Otago Hospital Board  
Board members  
Berendsen, K E (Dr)—Medical Superintendent-in-Chief  
Bolitho, D G—Chief Executive  
Mills, J W—Deputy Chief Executive  
Neame, J A—Chief Nurse  
Otago University  
Beresford, C (Dr)  
Clarke, M—Faculty of Medicine  
Hunter, J D (Professor)—Faculty of Medicine  
Stewart, R D H—Faculty of Medicine  
Palmer, B J

Palmerston North Hospital—Accident and Emergency Department  
 Palmerston North Hospital Board—Principal Nurses  
 Principal Nurses' Association of New Zealand Incorporated  
 Pryor, W (Dr)  
 Rea, H H—Department of Respiratory Medicine, Green Lane Hospital  
 Robertson, M S—President, Society of Otolaryngology  
 Rotorua Hospital—Medical Superintendent, K F Green (Dr)  
 Royal Australasian College of Physicians  
 Royal Australasian College of Radiologists (New Zealand)  
 Royal Australasian College of Surgeons  
     Faculty of Anaesthetists  
     New Zealand Committee  
 Royal Australasian and New Zealand College of Psychiatrists (New Zealand)  
 Royal New Zealand College of General Practitioners  
 School of Medicine—Auckland University  
 Scott, M  
 Short, D P (Dr)  
 Society of General Practitioners  
 Soroptimist International of Nelson Incorporated  
 South Otago Hospital Board—Ellis, A J  
 South Canterbury Hospital Board—Nind, G  
 Southland Hospital Board—Pannet, J R  
 State Insurance Office  
 Sunnyside Hospital—Medical Superintendent  
 Taranaki Hospital Board—Eaddy, J H  
 Thames Hospital Board  
 Timaru Hospital—Medical Superintendent-in-Chief  
 Tucker, W N  
 Victoria University of Wellington  
     Social Work Staff Group—Department of Sociology  
     Women's Studies—Bunkle, P  
 Waikato Hospital Board  
     Community Health Service—Rex Wright St Clair (Dr)  
     Cull, A B (Dr)—Paediatrician, Waikato Hospital  
     Dunshea, M G  
     Kerr, M J—Treasurer  
     Neilson, N C—Chief Nurse  
     Rothwell, R P G  
     Senior Medical Staff  
     Sinclair, A J (Dr)—Medical Superintendent-in-Chief  
     Sommerville, A J (Dr)  
     Wallace, M (Dr)—Renal Physician, Waikato Hospital  
 Wairarapa Hospital Board  
 Waitaki Hospital Board  
 Wanganui Area Health Board  
     Driver, P  
     Executive Officers  
     Hannon, R—Chief Pharmacist  
     Macdonald, D A  
 Wellington Clinical School of Medicine  
     T V O'Donnell (Professor)  
     L A Malcolm (Professor)  
 Wellington Hospital Board—Heads of Regional Clinical Services  
 Wellington Hyperactivity and Allergy Association Incorporated  
 Wellington Infertility Society Incorporated  
 West Coast Hospital Board  
     Board members  
     Deputy Chief Executive  
 West, H G  
 Wilson, J