

Resourcing and clinical governance: The case of New Zealand

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The majority of Commonwealth member countries face considerable challenges in developing crucial infrastructure and services to deliver to the vast needs of their populations. Priorities for developing countries include extending the skills of a limited and strained workforce, training and retaining health professionals, procuring medical supplies and medicines, and making services accessible. In this context, reflecting on funding and governance models might sometimes be viewed as a luxury that is largely reserved for well-resourced countries.

Yet as Commonwealth countries develop and incorporate health care into their development agendas, questions around models for funding, governance and service planning naturally arise. This brief article considers the role of funding, which is pivotal if countries are aiming for equity in service access and health outcomes. It also discusses governance and, in particular, clinical governance as an important leadership model. Finally, it introduces the idea of an 'alliance' between different players in a local health system as a potential model to bring together funding and governance for effective service planning. The article draws upon developments in New Zealand, where there is a strong focus on reducing inequality and delivering on goals of equity in government policy, on clinical governance and on collaborative service planning.

Funding, governance and planning questions

A range of health funding methods exist. While no two health systems are comparable when it comes to funding arrangements, broad similarities can be found. When countries are aiming for equity, the funding method for delivering on this comes into focus. As a general rule of thumb, private funding – via insurance – tends to drive inequities. Some countries feature social insurance, which can tend to complicate planning and lead to patient- or provider-induced demand. Donor funding is an important source for many developing countries. Many Commonwealth countries feature government tax as the backbone of health care funding with a fundamental aim of freely and universally accessible services. As noted, none of these methods are perfect. Where aims are for equitable distribution of funding, given that populations and health care needs are likely to differ between regions within a country, there is a need for models that reflect this.

Governance might generally be considered to describe arrangements for governing the organisation and management of health services and professionals, including how funding is allocated. Naturally, governance arrangements can have

considerable impact depending on focus, who is involved, how those involved obtain their positions, what skills they bring and how they behave. Perhaps the most important function of governance is providing strategic direction and then monitoring the activities and performance of managers and services. Tensions can arise between governing bodies and employees, including health professionals delivering front line services, who may have different perspectives from those at the governance level (Hogan et al., 2007).

Funding and governance arrangements naturally link into planning, with each of the aforementioned funding models having a significant impact on what is achievable. Robust governance, which is inclusive of health professional and community views, can similarly produce more coherent planning and accountability.

The New Zealand case

New Zealand has a tax-funded health care system with foundations in the 1938 Social Security Act which aimed for equity and universal access to a full range of services, as well as a focus on preventive medicine and service integration. Around 80 per cent of health funding is from government sources, with the remainder from private insurance and out of pocket payments. Funding and ownership of public hospitals is devolved to 20 district health boards. Public hospitals are free of patient charges and universally accessible. Private hospitals provide only elective services and receive no government funding. Primary care is largely provided under a series of Primary Health Organisations. Primary medical care is mostly privately provided, albeit with considerable government subsidies. This means patients face co-payments to see a general practitioner, creating access problems for the less well off. Moreover, there continue to be health inequalities, with Māori and Pacific life expectancy around a decade shorter than other New Zealanders (Tobias et al., 2009). Yet New Zealand has worked in a concerted way to reduce inequality, starting with how public health care funding is distributed.

Population-based funding

New Zealand is one of a small number of jurisdictions (including the UK) that uses a population-based funding formula (PBFF) for health. A PBFF is designed to ensure that funding allocation is based on the characteristics and health needs of a population, recognising that these are likely to vary. In a comparative study of PBFFs in seven jurisdictions we found that the underlying principles were similar, but the formula composition in each differed (Penno et al., 2013). This reflects the fact that a PBFF is only as good as

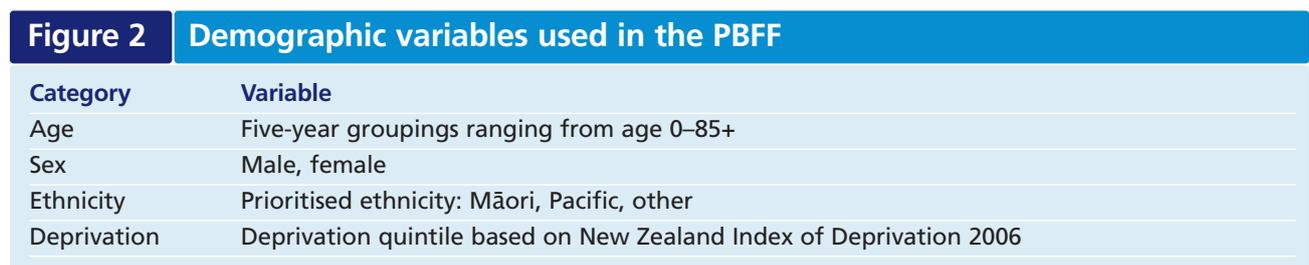
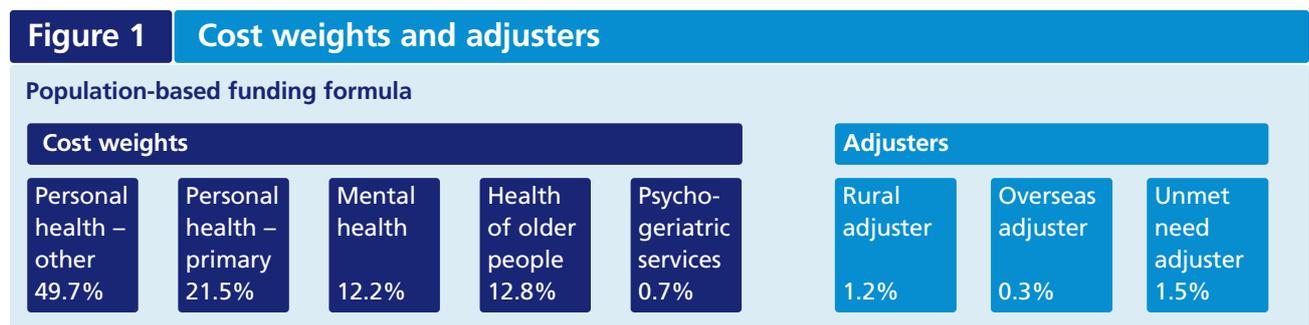
the data available to policy makers, but also that decisions around composition often mirror policy priorities. The primary advantage of a PBFF is that it focuses on a population rather than individual patients, so it can be configured to ensure that the most disadvantaged or unwell populations receive proportionately more funding per capita.

While New Zealand’s PBFF is not without flaws (such as the use of sometimes outdated census or other data, limited clarity around how some of the final figures in formula categories are derived, and a lack of recognition of a rapidly changing and increasingly ethnically diverse population), it offers a fairer and more transparent allocation method than the alternatives. It is constructed in a series of steps. First, the government determines the overall sum available for health care in the financial year. This is then allocated to New Zealand’s 20 district health boards via the PBFF. The starting point for this is a simple average amount per person in the population, derived from the total. A series of five ‘cost weight’ categories, based on historical services utilisation, determine the flow of funds into different services as illustrated in Figure 1. Over 95 per cent of funding comes via the cost weights, within which the ‘personal health: other’ category, mostly hospital care, is dominant. The funding allocated into the different cost weight areas is adjusted according to four demographic variables: age, sex, ethnicity and deprivation. As in Figure 2, the age structure of each region’s population will affect its allocation, as will deprivation (socio-economic status) or the proportion of Māori and Pacific people. The remaining funding is allocated via three ‘adjusters’. Districts that span rural areas receive an adjustment to reflect travel and other associated needs, as do districts with higher numbers of foreign tourists (‘overseas adjuster’). The ‘unmet need’ adjuster is allocated to districts with specific problems of poor health and service accessibility. The end result of the various calculations is around a 25 per cent difference in funding per capita between the 20 districts. Concentrated urban populations tend to receive less funding than more deprived rural districts.

Governance and ‘clinical governance’

New Zealand’s 20 districts have long featured elected governing boards. While there are questions around these boards’ effectiveness, the country has, since 2009, committed to a governance model at the service planning and delivery level with origins in the UK NHS. Known as ‘clinical governance’, this is the idea that both professional standards and service quality can be improved if health professionals are involved in, and take ownership of, all aspects of decision making, including planning how funding will be allocated within a region and how services will be designed, through to how resources will be utilised within a hospital ward or primary care facility (Halligan and Donaldson, 2001). In this way, as a working party on development of clinical leadership in New Zealand suggested, the whole health care system is ‘in [the] good hands’ of professionals (Ministerial Task Group on Clinical Leadership, 2009). A range of concepts sit behind clinical governance. Most important is the idea that health professionals are best suited to monitoring quality of care, where there are flaws in the systems of care (including standards of professional peers), and to making resourcing decisions and evaluating how these will impact on patients. In sum, clinical governance means health professionals have two jobs: providing high quality health care, and improving the health care system. In practice, it means a leadership partnership between managers and professionals; that professionals work as teams, especially inter-professional teams; and that all professionals and the institutions involved in their training and registration commit to the ‘two jobs’ idea.

The path to developing clinical governance is not straightforward, especially where systems have been run by managers, are under-developed, professionals are overwhelmed with clinical duties or lack fundamental managerial skills. In 2009, in New Zealand, the government gave specific instructions to the 20 districts for managers to build leadership structures which involve health professionals as partners in all levels of their organisations, covering the entire patient journey; that they seek to identify and support



clinical leaders; and that there be joint accountability between management and health professionals for both financial and clinical performance and quality. A considerable effort has since been made to these ends.

I have led two separate studies of clinical governance implementation, involving both survey and case study methods (Gauld and Horsburgh, 2012). We found that between 2010 and 2012 health professionals perceived an improvement, as measured by the Clinical Governance Development Index (key items are in Table 2), but the overall score was still rather mediocre. Despite this, the emphasis on clinical governance has been positive for health professionals and managers. Our case studies provided insights into the mechanisms which assist clinical governance development. These included the observation that what was meant by 'clinical governance' needed clear definition; that robust management-clinical partnerships are required, along with a multi-layered developmental strategy and investment in training; and that clinical governance also requires organisational arrangements such as a clinical board that brings together the various professional and managerial leaders and which is empowered to make resourcing and service configuration decisions and be accountable for these.

Alliances

New Zealand's organisational arrangements for planning and funding health services are presently moving into new and promising territory. Building on clinical governance and based on a collaborative philosophy of 'we are all in this together', this differs from, say, a public-private partnership. Following pilot projects, from 2013, the government has required Primary Health Organisations in each of the 20 districts to enter into an 'alliance' with their respective district health board. The alliance concept derives from the construction industry where a range of businesses will form an alliance to ensure that a project is completed on schedule and within budget. Partners agree to help

one another and share resources where relevant to contribute to the common goal.

Translated into New Zealand health care, an 'alliance leadership team' is clinically-led and includes doctors, nurses, allied professionals and managers from across primary and hospital settings. Members sign a charter which spells out their commitment to a 'whole of system' approach to planning, to casting aside their particular professional or ownership interests and to focusing on how the health system is best designed from a patient perspective. They also agree to share resources through creation of a 'flexible funding pool' to be invested in new cross-sectoral service integration initiatives and commit to helping one another out to achieve common goals. Some alliances feature non-government and private service providers, such as pharmacists or laboratory services (which are private businesses in New Zealand but contract with the public system) or ambulance services (provided by charitable trusts and also working closely with the public sector). The emerging alliances are typically structured with a series of 'service level alliances', each composed of health professional leaders who work together to improve care systems. An example is hospital outpatients where specialists may provide training and support for primary care doctors so that routine conditions and patient follow-ups can be done in primary care. Another is better primary care emergency response systems so that patients do not necessarily need to be transferred to hospital.

Conclusion

We know that Commonwealth member countries, along with the broader international community, are focused on a series of development goals, many of which promote health and health care. If health goals are to be realised then it is critical for policy-makers to consider the mechanisms for funding, governance and service planning where multiple options and combinations of these exist.

This article has outlined present policy directions in New Zealand, which draw upon and adapt developments elsewhere, and offer an example of methods for promoting population coverage and equity, with health professional leadership. Of course, each country is to a degree bound by the historic institutional arrangements that underpin its health system. This poses challenges for moving in new directions. The key for member countries focused on development and equity is to look abroad for examples of promising health policy initiatives that foster these objectives, adapt them for local circumstances and then build a consensus around them amongst policy makers, health professionals and the public.

The NZ-UK Link Foundation is an organisation promoting the sharing of academic excellence between New Zealand and the UK. Robin Gauld is the foundation's Visiting Professor for 2014 and will be delivering a series of lectures throughout the year on their behalf. The fellowship is supported by the School for Advanced Study, University of London (also host to the Institute of Commonwealth Studies). Further information may be found at: www.nzuklinkfoundation.org.uk.

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Box 1 Survey

Clinical Governance Development Index health professional survey

To your knowledge, has your district health board (DHB) established governance structures that ensure a partnership between health professionals and management?

To what extent are health professionals in your DHB involved in a partnership with management with shared decision-making, responsibility and accountability?

To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?

To what extent do you believe that quality and safety are goals of every clinical initiative in your DHB?

To what extent do you believe that quality and safety are goals of every clinical resourcing or support initiative in your DHB?

To what extent has your DHB sought to give responsibility to your team for clinical service decision-making in your clinical areas?

Source: Gauld et al., 2011

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