From Great to Good; how a leading New Zealand DHB lost its ability to focus on equity during a period of economic constraint.

Prof Don Matheson

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Abbreviations:

ASH	Ambulatory Sensitive Hospitalisations
C&CDHB	Capital and Coast District Health Board.
DAP	District Annual Plan
DHB	District Health Board
ICC	Integrated Care Collaborative
SOI	Statement of Intent
P&F MT	Planning and Funding Management Team.

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Summary:

This is a review of the Capital and Coast District Health Board (C&CDHB) decision making around primary health care and equity over the last three years, based on the release of relevant papers requested under the Official Information Act.

It shows that during this period of economic constraint, the hospital sector expenditure grew relative to the primary health care sector. It also demonstrates that the historical pattern of inequitable access to primary care persisted, and unplanned admissions to hospital grew, suggesting increased inefficiency in the Board's operations.

C&CDHB's direction during this period decreased in scope and became increasingly focused on the Minister of Health's targets. This narrowing of focus crowded out the previous focus the Board had on equity for the population that it serves. While previously it had led performance in addressing equity, it is now actively disinvesting in the providers that helped secure that leadership position. This disinvestment also reduced its purchasing influence over the primary health care sector, which became increasingly nationally controlled, while at the same time pushed costs onto patients who could least afford to pay.

Inside the Board's decision-making and policy advice process, the increased tensions are manifest, with widely differing principles and approaches to prioritisation, and a lack of consistent application of evidence of impact to inform decision making.

The Board is embarking on a new strategy, Integrated Care Collaboratives, which calls for a reversal of the current trends of increased hospital admissions and decreased support for the primary care sector. This approach will struggle while the national signals remain tightly focused on the hospital sector, and whole system performance and complexity is not seriously considered in the way the system is led.

Introduction:

In mid-2012 I was asked by a community group to help them understand why the primary health care service they were using was having its funding reduced. The funding reduction occurred in spite of the commitment the New Zealand health system has to reducing disparities, improving frontline services, and improving access to primary health care[1]. The community's request led me to attend a Capital and Coast District Health Board (C&CDHB) meeting where the community's concerns were heard. However, the Board went ahead anyway and reduced the funding for a service that provides comprehensive primary health care to people on low incomes, including large numbers of refugees, people experiencing mental illness, and a high Māori and Pacific population.

In an attempt to understand the rationale used by the Board in reaching a decision that would seriously impact on the frontline services for a clearly vulnerable population I requested under the Official Information Act (OIA) (see Appendix 1) papers that would throw light on the Board's decision making processes between 2009 and 2012. This document is a report on the content of the materials supplied by the Board in response to the OIA request.

When assessing health system performance it is important to distinguish between higher order goals[2] (such as improved health outcomes, equity, meeting population health needs) and goals that are more instrumental – such as how to meet needs efficiently and within budget limitations. Efficiency[i] and cost containment aren't enough in themselves – they are only useful as a means of achieving higher order goals.

In this document, I focus on the decision-making processes and frameworks around primary health care[3] and health equity. I assume that primary health care is the epitome of a front line service, that it has a large influence on the equity of access to the other parts of the health system, and that it also influences the overall efficiency with which the district's health resources are used.

New Zealand does not have an equitable health system, despite its policy framework[4]. A recent Treasury report[5] shows an upper middle class household receives on average almost $11,000 of health services a year, whereas the households with the lowest income receive on average $6,000 of health services – despite their greater need. The extent of the unmet need nationally is seen in the latest New Zealand Health Survey[6], which reports that almost

[i] In this paper "Efficiency" when used, refers to "Technical Efficiency"... the way in which inputs to health care are optimised.

one million New Zealanders had unmet need for primary health care in the last year. This unmet need is not evenly distributed. Māori, Pacific and low income groups, who have the most need of primary health care services, experience the highest level of unmet need. Additionally, New Zealand compares unfavourably with other similar countries from an equity perspective. When the New Zealand health system is compared with those of Australia, Canada, Germany, the Netherlands, the United Kingdom and the USA, we have the second most inequitable health system, slightly better than the USA[7].

Nonetheless, at the start of the period under review, C&CDHB was making considerable inroads into reducing inequity in primary health care service provision[8]. Ambulatory Sensitive Hospitalisations (ASH) were low and decreasing compared to other DHBs in New Zealand, which saved the Board money in unnecessary and preventable hospitalisations. Given the extent of the systematic inequities in the New Zealand health system the performance by the Board in this regard held important lessons for the rest of the country.

In 2008 the global financial crisis reduced the rate of increase in health expenditure, and subsequently squeezed district health board budgets. This required a much stronger focus on prioritisation and increased the pressures on board decision-making processes.

Analysis in this paper addresses the following questions:

- How did the Board allocate its money to the different parts of the health system?
- How was equity considered by the Board's prioritisation and decision-making processes?
- What evidence is there of the impact of these decisions at the interface between primary health care (PHC) and hospital service activity.

Methods:

This is an examination of the C&CDHB decision-making process between 2009 and 2012.

A request under the Official Information Act 1982 (OIA request) was made to the Board in October 2012 and this defined the scope of the material requested and subsequently examined (see Appendix 1).

Sixty papers were received from the Board on 28 November 2012: 25 from the Planning and Funding Management Team and 35 from the Board.

These were summarised on a spreadsheet, and references to Board decisions or commentary about primary health care funding, equity, ASH, and low income practices were identified and recorded. A time sequence for advice and decisions was established, then the actions were grouped according to the five themes identified below.

In addition, District Annual Plans (DAPs) and Statements of Intent (SOI) were accessed through the internet. ASH rates were analysed from Ministry of Health (MOH) data available on the MOH website.

Limitations:

The paper primarily reports on the written record of the C&CDHB's deliberations. It does not record discussions the Board may have had that are not part of the written record, and it does not include information that may have been critical in decision making but fell outside of the scope of this OIA request. This paper should be considered an entry point into the Board's decision making, in the hope it will stimulate further exploration and understanding of the decision-making process of this important public institution.

How did the Board allocate its money to the different parts of the health system between 2006 and 2010?

Table 1 shows the Board's expenditure by selected areas[ii] from 2006/07 to 2011/12.

Table 1 C&CDHB expenditure 2006 to 2012 (thousand dollars)[iii]

Expenditure	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
DHB	684336	763761	840361	897321	916754	967157
Hospital	428516	477428	539959	577282	589267	631021
PHC	38182	44346	49538	54994	56409	58416
Maori and Pacific	3652	4183	3877	3970	3636	3902
Hosp as % DHB	63%	63%	64%	64%	64%	65%
PHC as % DHB	6%	6%	6%	6%	6%	6%
Maori and Pacific as % of DHB	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%

The Board's expenditure increased substantially over the period, but the rate of increase has been reducing since 2007/08, falling below the level of inflation in 2010/11 (see Table 2). Hospital expenses dominate (Figure 1) and are increasing as a percentage of the Board's budget, moving from 63 percent of the budget in 2006/07 to 65 percent in 2011/12. Māori

[ii] In this table, PHC refers to primary health organisations (PHOs), s88, GP/nurse subsidies, immunisations, not referred services, disability support, mental health or dental.

[iii] 28/11/12 – Director of Service Integration and Development- Official Information Request

and Pacific-specific expenditure peaked in 2007/08 then dropped from 0.5 percent to 0.4 percent of expenditure over the period. Primary health care expenditure has remained at 6 percent, and is a small part of the Board's overall expenditure.

Figure 1

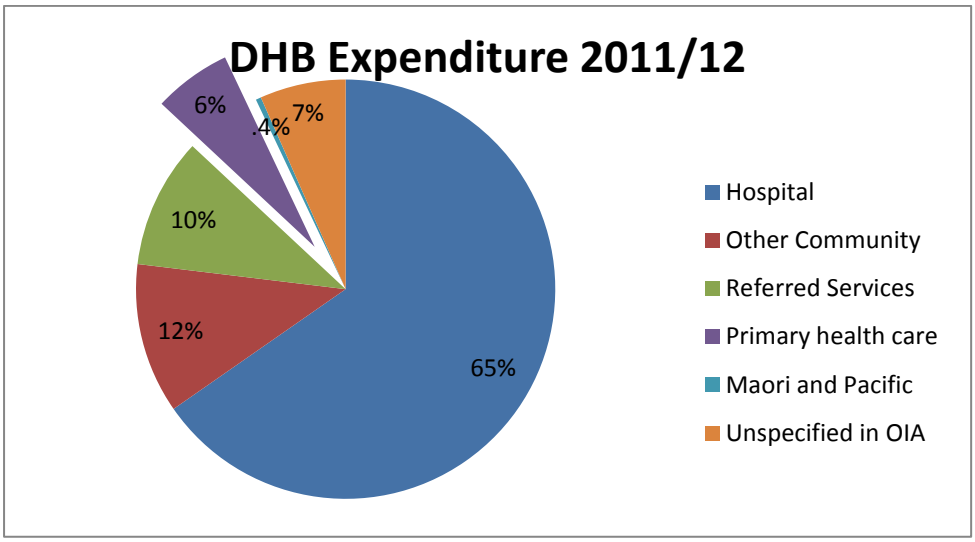


Table 2 compares the annual percentage increase in expenditure between 2007 and 2012 in three areas – C&CDHB as a whole, the hospital, and primary health care.

It shows a shifting pattern over the period, with primary health care expenditure growing faster than the annual rate of increase for the C&CDHB at the beginning of the period, but dropping below the overall rate of increase in the 2011/12 year. In contrast, it shows the hospital expenditure growing faster than the Board's expenditure in the 2011/12 year. The relative size of these budgets (as in Figure 1) is very significant here. A 1 percent increase in hospital expenditure is nearly $10 million dollars, whereas a 1 percent rise in PHC is less than $1 million.

Table 2 Annual rate of increase in expenditure

Expenditure	2007/8	2008/9	2009/10	2010/11	2011/12
DHB	763761	840361	897321	916754	967157
Rates of increase (DHB)	12%	10%	7%	2%	5%
Rate of increase (Hospital)	11%	13%	11%	2%	7%
Rate of increase (PHC)	16%	12%	11%	3%	4%

The Board has overseen a reduction in rate of increased expenditure over the period. This reduction has not been equally shared across the organisation, with the hospital showing an expanded share, while primary health care, and Māori and Pacific services have had a static or reduced share, from a very low initial base.

Did the Board's priorities change during this period?

This section traces the Board's priorities and approaches to decision making over the period. The aim is to explore changes in values and priorities and their influence on decision making.

The direction of health services at the Board level is strongly influenced by both the intentions of the Board, and the instructions from the Minister of Health. This direction is spelled out in the DAP each year. The DHB uses a number of different headings in the DAP to signal its higher order intentions. These headings include its Vision, Values, Strategic Objectives, Goals, Local Priorities, and Minister's Priorities.

An examination of the District Annual Plans from 2008 to 2012 reveals a number of interesting points about how Board intentions are expressed.

Vision and Values

The Board's vision and values remained the same throughout the period.

Vision:
Better Health and Independence for People, Families and Communities

Values:

- Innovation
- Action
- A focus on people and Patients

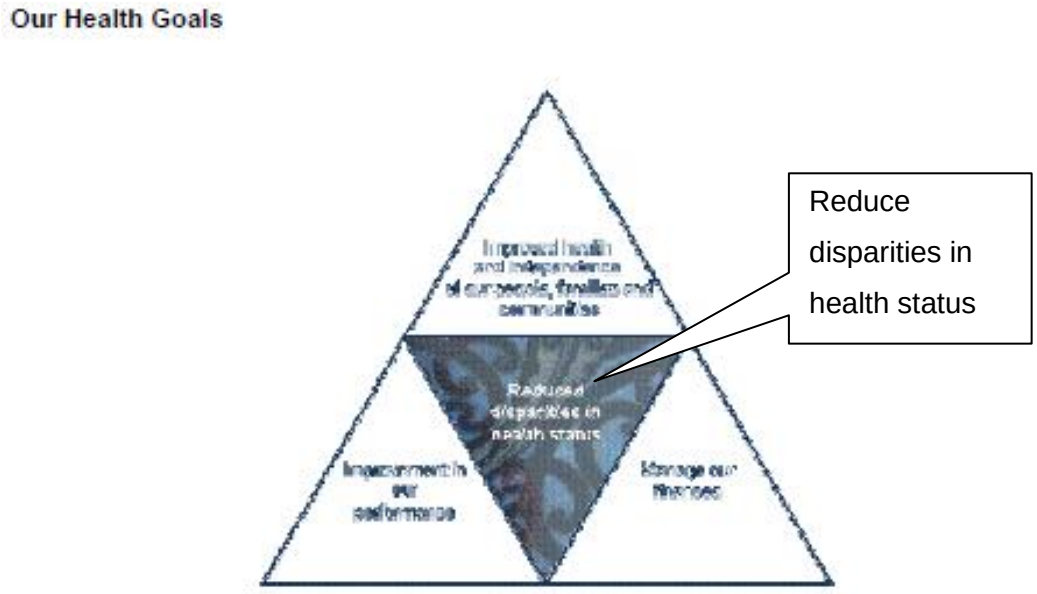
- Living the Treaty of Waitangi
- Professionalism (leadership, honesty, integrity and collaboration)
- Excellence (effectiveness and efficiency)

Of interest to this discussion is the absence of any reference to equity or fairness in these two high order statements, despite their prominence in the empowering legislation9.

Strategic Objectives, Goals, Local Priorities and Ministers Priorities

These features changed over the period, particularly for reducing disparities, the principal means of addressing inequality at a district level. In 2008/09 reducing disparities was seen as central in the DAP, illustrated in Figure 2:

Figure 2 C&CDHB District Annual Plan 2008/9



In 2009/10, the focus on disparities moved from the diagrammatic representation of 2008/09 to the first strategic priority:

> *Our central focus is on improving the health of our local people, families and communities – and reducing inequalities within our population*.

By 2009/10 the main strategic priority had become:

> *Achieving Minister's Health Targets, and Expectations"* and reference to equity in the strategic statement had been changed to *"Supporting Vulnerable Communities.*

Under a heading "Our Health Goals", the idea of reducing disparities was referred to as:

> *Improving the health of our local people, families and communities – and reducing health disparities within our population*.

In 2011/12 equity concerns had returned to lead the strategic priority list*:*

> *The reduction of health disparities within our population"* and also appeared in a new category called "Local Priorities" as: "*Reducing disparities within vulnerable communities. Improving the health of children in vulnerable communities*...

The positioning and wording related to health equity changed during this period. The strongest expression was in 2008/09, where reducing disparities in health status was seen as central to the Board's activities. The weakest expression was in 2010/11, where in the strategic objectives reducing disparities was reframed as "Supporting vulnerable communities". In 2011/12 the Local Priorities weakened this focus further with its reducing disparities "within" vulnerable communities, as opposed to the usual understanding of addressing disparities between different populations. However, is the Board has clearly attempted to continue to highlight equity in its high level statements, even if its positioning and wording has been the subject of annual changes.

Notably, the changes in emphasis in the DAP correlate with the Board's understanding of the Minister of Health's intentions. The Minister's intentions also changed over this period. An examination of the DAPs from 2008 to 2010 (see Table 3) reveals the changes in the Board's perception of the Minister's intentions. Note this table shows how the Minister's intentions were expressed by the DAP, and is not a record of the Minister's actual written communication to the Board.

Table 3 Minister of Health's Priorities as expressed in the C&CDHB DAP 2008 to 2012.

Minister of Health's Priorities 2008-09	**Minister of Health's Priorities 2009-10**	**Minister of Health's Priorities 2010-11 and 2011-12**
Value for money – better value for money provides more health care for more		
	Sharply focused on hospital services [iv]	
Getting ahead of chronic conditions – maintain the pace of programme implementation		Better diabetes and cardiovascular services
Reducing disparities, especially for Māori and Pasifika populations		
Child and youth health – implement current programmes and build on the well child review		Increased immunisation
Primary health – improve the interface, through planning and working together with PHOs	Committed to Primary Health Care Strategy through building on relationships between primary and secondary care settings especially in the area of long-term conditions and laying appropriate foundations for shifting some secondary services to more convenient primary care settings and	

[iv] CEO and Chair's statement DAP 2009/10

	multi-disciplinary Integrated Family Care Centres.	
Infrastructure – especially workforce development and coordinated information systems		
Health of older people – continue to give priority to new service models		
	To improve services and reduce waiting times in emergency departments	Shorter stays in Emergency Departments
		Better help for smokers to quit
	To increase volumes of elective surgery.	Improved access to elective surgery
	To improve cancer treatment waiting times	Shorter waits for cancer treatment
	To halt the growth in the number of Full Time Equivalents within the Management and Administrative personnel category.	

The Minister's intentions went from broad goals in 2008/09 to discrete specific goals from 2009/10 onwards. Of particular interest are the increased emphasis on hospital services and increasing electives in particular, and the decreased emphasis on reducing disparities, primary care, and Māori and Pacific services.

The other important shift is the priority given by the Board to the Health Minister's intentions in the DAP. The Minister's intentions were given increased prominence by 2010/11 where it was listed as the Board's main strategic priority, and the DAP increasingly focused on the

Minister's targets from this point on. By the Statement of Intent 2012_2015 the Board was describing itself as "An organisation configured to achieve health targets".

Looking at Table 3 it is clear there was a major shift in direction as expressed through the Minister's intentions between 2008/099 and 2009/10. This shift is much more significant than the Board's expressions of direction during the period examined. The Minister's direction increasingly dominated the Board's intentions and the content of the DAPs.

The characteristics of this shift were an increased focus on the hospital, on the volume of elective services, and on narrowly defined targets. This intense focus crowded out an emphasis on health equity and primary health care, and subsequently decreased the emphasis on populations such as Māori, Pacific, low income, children and the elderly. Changes in Board priorities naturally impacted on the decisions of the DHB Planning and Funding unit.

Decisions and priorities inside the DHB

The previous section examined the changes occurring at the Board level of the organisation. This section examines the processes occurring inside the organisation during the same period. The papers referred to are from the Planning and Funding Management team, the technical advisor on planning and funding to the C&CDHB Board, and from the Board itself. Quotes from the papers are in italics. Decisions are traced sequentially from 2009, analysing changes in discourse about equity, as well as approaches to matching funding of services to health need.

Decision making to reduce expenditure across the organisation limiting its strategic options:

The CEO decided from the outset the magnitude of the "contribution" each part of the DHB would make to the required deficit reduction. Primary care funding is channelled through the Planning and Funding budgets:

> *Planning and Funding has been tasked with finding $10m per annum from July 2010*[v]

The paper acknowledges that this was a shift from the past where equity was a major concern:

> *Many investments in the past 8 years have been made on the basis of reducing inequalities*[vi]

[v] 05/10/09 Planning and Funding Management Team. Topic: Draft minutes of Savings meeting

No evidence was provided in the OIA response of how the $10 million "contribution" was calculated, and whether it took population health need or inequalities into account.

This decision about contributions had important implications. It appears to have been made in response to the financial situation without any prior analysis of different strategic options to tackle the deficit, which limited thinking about the system as a whole, and led to a focus on particular budget lines and particular contracts. It was at this point that a major strategic option, which would have been to increase investment in PHC to better manage the whole of C&CDHB's activities and its deficit, was closed off.

Decision-making templates and scoring mechanisms were developed to focus on specific budget lines, but the results of these do not appear in any of the key decision making papers, and as the 5 October Management Team meeting notes:

> *Many templates were not fully completed and thus do not give an accurate assessment of risk or impact of associated change*.[vii]

Principles by which decisions are made

In the documents leading to 2010–11 prioritisation, the process aimed to identify contracts to be ring-fenced and to have funding protected by the following principles[viii],[ix]

- *Low cost services targeted to vulnerable communities*
- *Services targeted to low income, Māori and Pacific communities that are focused on disparity reduction*
- *Services to low income, Māori and Pacific communities where such services CANNOT [sic] be accessed through mainstream provision*
- *Diabetes and cardio vascular services that can effectively demonstrate a connection to long term health outcomes and reduced burden on secondary and tertiary services*
- *Health services targeted to children.*

This was a two-step process. The first step was to check whether a service was eligible for ring-fencing by ascertaining whether it targeted high needs or vulnerable populations. The second step was to see if the remaining services contributed to one of the Minister's Health

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[vi] 05/10/09 Planning and Funding Management Team. Topic: Draft minutes of Savings meeting

[vii] 05/10/09 Planning and Funding Management Team. Topic: Draft minutes of Savings meeting

[viii] 21/09/09 Planning and Funding Management team – Funding review template.

[ix] 21/09/09 Planning and Funding Management Team – Capital and Coast DHB 4 Stage Disinvestment Process (Primary Care)

Targets. If the service did not contribute to the Health Targets it was released immediately to the savings programme.

However, this approach to prioritisation did not remain constant. A month later the prioritisation criteria had changed to[x]:

Principles for Savings:

- *Least impact on vulnerable populations*
- *Least impact on front line services*
- *Least impact on avoidable admissions*

The emphasis had changed from "ring-fencing" services with a bigger impact on equity to assessing services as having "least" impact on equity. This change enabled the Management Team to then take an approach to cutting all services, without the constraint of a ringfence. It was an explicit decision to minimise the impact on equity as opposed to avoiding the impact on equity.

The following year (2010) the Planning and Funding team were instructed by the Board to make further funding reductions, and this precipitated further changes to the principles on which such decisions would be made[xi]:

Savings will be based on principles:

- *We will try to be innovative with less and affect front line services as little as possible.*
- *We will work with providers to make sure we go where the need is, and where the people who need us live.*

This statement signalled a significant change in strategy. It moved from taking a principled approach to ring-fencing services (and more latterly "least impact") to considering lessening the impact on "front line services" in general. More significantly, it signalled the move towards a much more provider engaged process, where the responsibility for protecting equity was based less on the Board's analytical work and more on providers' views of equity and where services could be cut. The Planning and Funding Management Team reported[xii]:

[x] 20/10/09 Planning and Funding Management Team – Headings for Collated Information from Senior Management Team

[xi] 16/03/10 – Planning and Funding Management Team 16 Mar 2010: Proposals for Saving $3 million from primary care contracts in 2010/11

[xii] 16/03/10 – Planning and Funding Management Team 16 Mar 2010: Proposal for saving $3 million from primary care contracts in 2010/11

PHOs were given the opportunity to work with their providers and to indicate areas where they believe services can be reduced or cut with the least impact on vulnerable populations or front line services

At this point, the idea of "duplicate" funding streams began to gain currency as a rationale for decision making. Duplicate funding referred to two funding streams for similar services. No detail is mentioned about analysis of the quality or population served by these, or whether they were duplicates only by virtue of a similar name or purchase unit code[xiii]:

areas we believed to be of lower value or covered by duplicate funding streams.

By 2011, this had become the rationale:

a reduction/ termination of contracts where duplicate funding sources are available would be the preferred option[xiv].

Areas where alternative funding options are available include:

- *Long term conditions*
- *Improved access funding*
- *Youth services*
- *DHB funded Primary Mental Health Services.*

The Planning and Funding Management Team was prepared to cut funding categories (such as improved access funding) where a similarly named fund was active, irrespective of whether they were at a level sufficient to ensure high need patients actually gained access.

Equity was not restored as a specific criterion, rather it was to be monitored through ASH:

Equity considerations: The reprioritisation plan has aimed to minimise the impact on the most vulnerable populations . ASH will continue to be monitored.

It is likely that the positive outcomes in C&CDHB have been achieved through the combination and synergy of the various funding streams. It is acknowledged that ensuring the vulnerable populations are supported to keep well is important for the overall population, however there may be some opportunities to review these services.

[xiii] 16/03/10 – Planning and Funding Management Team 16 Mar 2010: Proposal for saving $3 million from primary care contracts in 2010/11

[xiv] 28/03/11 – The Planning and Funding Management Team v28: Primary Care Contracts – Reprioritisation Plan 2011

Having made the case for the effectiveness of the funding, the paper then goes on to recommend reductions. It is silent on equity considerations; $3 million was thus identified.

A year later (February 2011), in a paper *Purchasing Plan for Improving Access to Primary Health Care Discretionary Fund*, new purchasing principles were introduced[xv]:

> *The overarching principles to guide the decision making around this fund*
>
> - *Purchasing must be **pragmatic** as some hard calls need to be made in regard to who is eligible to access this discretionary fund*
> - *Purchasing must be **targeted** in order to obtain the most efficient use of this limited fund and ensure the fund complements other funding pools (eg SIA) rather than create duplication*
> - *Purchasing must be **outcomes based** and **measurable**, which will require mutually agreed indicators of success, and acceptance that favourable results will take time.*
> - *Purchasing must be **relationship driven** where the funder/provider rapport is deemed as important as the results being sought, and accountability is viewed positively. And where community participation is highly valued.*

In this iteration of principles, equity has disappeared entirely and the strongest expression – and power – is given to efficiency and provider relationships, where "*funder/provider rapport is deemed as important as the results being sought".*

This new set of principles was not sustained, and the Planning and Funding Management Team [xvi] in its March 2011 meeting had restored the principles to:

- *Least Impact on vulnerable populations*
- *Least impact on front line service delivery*
- *Least impact on avoidable hospitalisations*

Monitoring the impact of its decisions

Throughout the papers, reference is made to the importance of monitoring the impact of the Board's decisions.

The Planning and Funding Management Team noted that[xvii]:

[xv] 10/02/11-Board paper – Title: Purchasing Plan for Improving Access to Primary Health Care Discretionary Fund

[xvi] 28/03/11 – P&FMT- Primary Care Contracts- Reprioritisation Plan 2011

> *Monitoring will be undertaken over the next year to determine if these savings are impacting on vulnerable population groups leading to increases in ASH*.

The impact on ASH was taken up in the DAP, but rather than focusing on vulnerable populations, it expressed its intentions to reduce the Board's performance to be closer to the national average. [xviii]

> *ASH to remain below* 95*% across ethnicities and age groups*

This is the first reference of the Board setting its own target for the C&CDHB'S ASH performance. As the each DHB's statistics are indexed to the national average, below 95 percent is taken to mean 95 percent of the national average. As the C&CDHB had ASH rates well below the national average (between 82 and 90%), this target leaves plenty of room to worsen their performance.

The Board's decision highlights the problem of indexing ASH rates to the national average in a situation where the country's (ie the national average ASH) performance is poor. It does not incentivise high performing Boards to improve – on the contrary, as in this case, they aim for slightly better than average national performance, which is itself poor, and can therefore mask a deteriorating ASH situation for the Board. There is also little attention paid to using ASH as a potential savings mechanism, as improved ASH rates would decrease hospitalisations, and subsequently provider costs.

The Planning and Funding Management Team did develop a detailed analytical paper on primary health care funding as it impacts on equity in August 2010, which was made available under this OIA request. It stated[xix]:

> *national funding mechanisms had not met the needs of our most vulnerable population*.

It concluded:

> *the underlying precariousness of health funding for high needs population has never been adequately addressed in a systematic way through the existing national funding*

[xvii] 16/03/10 – Planning and Funding Management Team 16 March 2010**:** P&FMT

[xviii] 05/10 – Board – District Annual Plan 2010/11

[xix] 09/09/2010 – Planning and Funding Management Team Topic:Systemic PHO Funding Gap and Sustainable Funding

> *formula. C&CDHB's discretionary fund, to some extent, addresses this funding deficit.*

The management team

> *found the analysis report was a useful tool, but needed to wrap context around the report and to use it in terms of improving access. MT noted that this report was not to be taken to PHOAG (*PHO Advisory Group*)*.

It appears the report was not taken further (with or without a wrapping of context). However, key analysis in this report was used to inform a subsequent paper; *Review of Improving Access Funding in Primary Care***,** which is discussed below.

From the above it is clear the organisation had discussed ASH as an indicator to inform decision making, but there does not appear to be any detailed analysis of the Board's performance since its monitoring report was published in 2010. The declaration of an ASH target well below the Board's then current level of performance is of real concern. The organisation had, however, done a detailed review of the funding and productivity of providers serving the most vulnerable populations. There is little evidence to suggest that the implications of this paper were considered in subsequent funding decisions.

Budgetary discretion of the Board over PHC funding

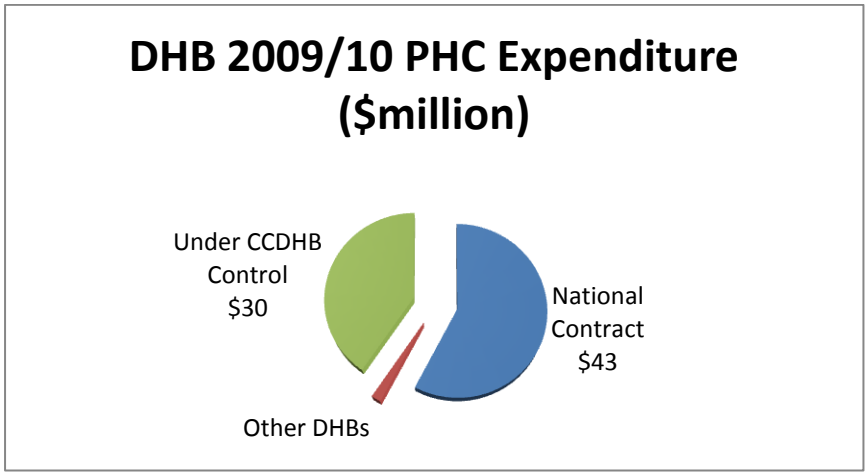
Although on the face of it the Board has control of its budget, in reality it can make decisions over only a part of its budgetary allocation. Decisions made by the Minister (through MOH) and other DHBs limit its financial decision-making authority.

Of the Board's $741 million expenditure in 2009/10, it felt it had decision-making power over only $371 million, or 50 percent. The rest was controlled by national contracts and other DHBs. In primary and community care[xx], of the 2009/10 expenditure (see Figure 3), the Board believed less than 40 percent of its expenditure to be under its control, the remainder being under national contracts and other DHBs[xxi].

[xx] In this 'PHC' I have included HEHA, Population Health, Pacific Health, Māori Health, personal, primary mental health.

[xxi] 21/01/10 Board Paper. Topic: DHB Efficiencies 2010/11

Figure 3 Financial Authority of the Board over PHC.



When the Board decided to reduce funding by $10 million a year, it inevitably targeted the one third of the Board's discretionary primary and community care budget (the green area in Figure 3). Whether funding could be reviewed or subjected to savings was not decided based on equity across its whole budget, but on the small proportion over which it had decision-making power. The $10 million would be saved from services the Board had previously funded to improve equity, thus equity focused primary care providers were disproportionately targeted. This shifted the underlying principle from one of equity to one of administrative practicality.

The Board paper identifies some "savings" in three areas where inequity was already an issue: Māori and Pacific, Long-term Conditions, and Funding to Improve Access[xxii].

> *Maori and Pacific Health: $0.87m in 10/11 then $1.47m annually*
>
> *Rationalise investment in long term conditions to a comprehensive package of services targeted to CVD, diabetes and renal. $0.9m annually.*
>
> *Reduce additional funds paid to PHOs and primary care providers above base PHO funding for improved service access. DHB funds an additional $1.6m, and is unable to sustain this. $0.9m annually.*

The outcome of this reduction was recorded as *"Reduced expenditure" (*presumably to the Board*)* but no other information on impact was presented. Of particular concern is the lack of analysis of the shifting of these costs onto vulnerable communities.

[xxii] 21/01/10 Board Paper. Topic: DHB Efficiencies 2010/11

The 20 January 2010 Board meeting was a pivotal decision-making meeting. Although areas of saving were identified, no evidence was presented in written form on the actual impact of savings on services or the Board's objectives.

The other impact of this decision was that the Board's budgetary discretion was even further reduced in the following year[xxiii], as its control over PHC funding had shrunk from 40 percent to 36percent.

> *The DHB has discretion to make investment decisions on a relatively small amount of funding (397.5m under control of DHB, out of 778.6m, for Primary and community care $25m out of 70m). The rest is for core services that are driven by national decision making processes or match current demands for hospital services.*

The paper presents a table of indicative savings for 2011/12, with "contributions" of $10 million in 2010/11, $20 million in 2011/2, rising to $25 million in 2013/14.

The largest contribution is from Primary Health and Community funding, contributing $3 million in 2010/11, then $6.1 million in the remaining years, giving a total of $21.3 million over the period.

The Board's shrinking "purchasing power" over the primary health care sector points to the real difficulties of a partially decentralised funder. Although nominally in control of the sector, most of the decisions are being taken elsewhere. The Board unfortunately responded to this by focusing its savings on the part of the sector it did have control over, without assessing the sector's relative worth.

The relationship between planning advice and needs assessment and actual budgetary decision making.

The Board's 2010/11 DAP argues strongly for a primary health care approach, then notes[xxiv]:

> *Current DHB financial constraints presents a challenge for the DHB as we need to reduce investment in primary care by $3m... this at a time when the national investment in primary care is also coming under pressure and reductions of $25m nationally have been requested by the Minister of Health.*

In November 2010, the Planning and Funding team undertook a review of Improving Access Funding in Primary Care. It described its approach or purpose as consolidating duplicate

[xxiii] 21/01/11- Board – Topic: DHB efficiencies 2011/12

[xxiv] 05/10 – Board – District Annual Plan 2010/11

funding lines, reducing the administrative burden on providers, and updating service specifications[xxv]:

> *This review is timely as the phased implementation of the primary health care strategy has led to new funding streams that appear to duplicate some of the finding applied through these contracts and there also appears to be opportunity to consolidate funding into fewer more accurate specified contracts with providers.*

Note that the review focused on the bureaucratic/administrative level of funding, not the population health impact or performance of the services that the specifications described. An example of this lack of analysis is in its description of the refugee programme. The draft review identified savings that could be made in the refugee programme, particularly:

> *while there are understandable health benefits, it is questionable whether 1.5 FTE social worker time is most appropriately funded from the limited funding pool ... funding be reduced to $500,000.*

No evidence was presented on either the "*understandable health benefits*" or why social workers were not "*appropriately funded"* from the pool.

However, the overall findings of the review argued quite strongly for increased funding for primary care providers serving high needs populations.

The paper presented evidence on service uptake by high needs populations. Key finding were[xxvi]:

- High needs patients in the 25–64 age bracket were severely underfunded in the capitation formula.
- Ora Toa and Well Health had higher numbers of visits per year for high need clients, and that visit rates for these two PHOs were increasing annually between 2007 and 2010.
- Well Health was the only PHO with a higher visit rate for "high needs" populations than "not high needs" populations.
- There was a real funding shortfall to adequately address the health needs of the refugee population.
- Significant gains in health outcomes had been achieved over a short time.

[xxv] 22/11/10 – Planning and Funding Management team – Review of Improving Access Funding in Primary Care.

[xxvi] 26/01/13 – Board- Review of Improving Access Funding in Primary care.

- C&CDHB should continue to invest in this area and apply outcomes monitoring as in the Board's 2010 monitoring report[8].

The paper strongly argues for the need to supplement PHOs in high need areas because of the inadequacy of the national funding formula when confronted with concentrated populations of high need patients.

The paper notes this shortfall worsened after the MOH decision (effective July 2009) phasing out Very Low Cost Access payments to PHOs, which adversely impacted on practices with high numbers of low income/Māori and Pacific clients, cutting their income by 13 percent. It concluded:

> *that a "one size fits all" tactic to funding based on an "average" population is not equitable, if the intention is to improve the health status of all.*

This paper did not meet with universal support from providers, as the Planning and Funding Management Team noted[xxvii] :

> *The Compass PHO attacked the findings as "extreme in their bias", Well Health PHO supported the findings.*

This is an expression of the tensions within the sector between mainstream providers and smaller providers servicing concentrated high needs populations. It is unclear how this divergence of views actually impacted on decision making as it is not referred to again.

From the OIA records, there is evidence that the Board members were becoming more concerned with the equity implications of the decisions they were making in the lead-up to the 2011/12 decisions[xxviii].

> *Board requested that a column be included in table titled "population Impact"(of the Recovery plan agreed with the Ministry in 2008/9*).
>
> *there is a need to identify and mitigate risks to population needs* [sic]

Two Board members, Ritchie and Choat, voted against the package.

Similarly, in discussing the District Annual Plan, members were: [xxix]

[xxvii] 04/04/11 April 2011 (P&F MT) Topic: Discussion paper : Improving Access Funding in Primary Care.

[xxviii] 04/02/11-Board Meeting-

[xxix] 04/02/11 – Board Meeting

Concerned by the impact on vulnerable populations of the changes to community based funding.

Board members also raised concerns that the values expressed "*do not reflect values as discussed at the Board workshop.*" The growing gap between funding and services requirements was directly discussed in a Board paper in February 2011[xxx]**:**

PHOs with the highest proportion of high needs patients have not gained as much as PHOs where lower proportion of Maori, Pacific and low income people are enrolled. ...clustering "very high needs" populations around particular PHOs is not recognised in PHO (and historical) funding approaches.

The purchasing plan also acknowledges the magnitude of the support needed for high needs populations, stating:

C&CDHB also agrees that there are those who require intensive and ongoing support and management of their health needs ... very high needs populations.

It also refers to an international study[10] demonstrating that high needs populations use 3.5 times the resources of the population average, and very high co-morbidity patients are expected to use 10 times the population average.

This information was not then followed with any more detailed analysis of actual resource use by the high needs groups in C&CDHB populations and how this differs from the international benchmark.

On 22February 2011 the Board discussed the second draft of its DAP. Under its 'stewardship' role the Board describes itself as:[xxxi]

An Organisation Configured to Achieve Health Targets,

by which it means the Minister's specific targets and not health targets in general.

In health sector terms, stewardship normally refers to issues such as providing vision and direction for the health system, collecting and using intelligence, and exerting influence – through regulation and other means. Confining the role to a narrow set of targets is an abdication of a broader stewardship role.

[xxx] 10/02/11– Board paper – Purchasing Plan for Improving Access to Primary Health Care Discretionary Fund

[xxxi] 25/02/11– Board-Topic: Second Draft Annual Plan 2011/12.

The April 2012 Board meeting clarified its intention by stating[xxxii] *"The top priority must be living within our means/ living within our budget*". One member, Helene Ritchie, had a dissenting view.

The mounting pressure on the Board and its decision making is seen in the lead-up to the 2012/13 DAP. An issues paper for the plan contains an outline of the situation for the coming year[xxxiii].It puts forward the option of "*Disinvestment of locally prioritised services*" saving $8.9 million. This would largely remove all primary and community investments the Board had made to address equity in the past, and the Board would have an even more diminished role as a purchaser of primary care.

The paper also warns of the dangers of doing this:

> *it is expected that there would be more admissions to hospital and higher ASH rates in the shorter term. Longer term there may be impacts on inequality indicators for high need populations in high deprivation areas. It is likely the co-payments would reduce access to services to some populations groups although this would be mitigated if such charges were to non CSC holders. A change in inequality funding is likely to impact adversely on the sustainability of primary care providers who work with high needs population groups which in turn lead to higher hospital admissions, poor ASH rates, and reduced access to services.*

In its April 2012 meeting it appears the Board had not been swayed by these risks, but was taking a position of abdicating responsibility to the National Health Board (NHB) and the Minister, more concerned with compliance with national service schedules and consultations processes around funding cuts[xxxiv]:

> *This investment in "improving access" is over and above core services outlined under service coverage schedules.*
>
> *Service changes discussed with the NHB which indicated it does not believe the Minister will require C&CDHB to consult on the service changes.*

The Board Annual Reports and SOIs show an increasing dislocation between its population's "Needs Assessment" and its funding decisions.

[xxxii] 01/04/11 -Board- Board Meeting – DAP 2011/12.

[xxxiii] 2 Dec 2011 Annual Plan 12/13 issues paper

[xxxiv] 03/04/12 –Board-

The 20012/13 DAP makes a compelling case for Health Promotion and addressing the rising obesity epidemic[xxxv]:

> *Current trends indicate sustained increases in obesity in New Zealand's adult population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy. Supporting the population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of the population and to the prevention of chronic conditions and disability at all ages.*

This is then followed, in the same paper, by funding decisions which do the opposite:

> *Health promotion services: These services are delivered by PHOs and have been previously funded through MoH HEHA funding. The Ministry has advised the DHB that existing funding arrangements will end on 30 June, but that a contestable process for a reduced amount of funding is to be implemented in 2012. Should the process allow, the DHB will support PHOs in their application for funding through this process to continue with their current services, or identify other service opportunities. If funding is unavailable through the contestable process however, these services will cease to be funded by the DHB.*

The same paper also heralded similar reductions in support for breast feeding.

In April 2012 the Board were introduced to the work done on a new approach in the previous year, Integrated Care Collaborative (ICC)[xxxvi].

The development of the ICC process is based upon the principles of *Triple Aim* change management. These are:

- to improve the quality, safety and experience of care
- to improve health and equity for all populations
- to gain the best value from the resources made available to the public health system.

Under the benefits of ICC activities, the Board paper refers to Improved Population Health Outcomes but documents improvement in reporting and monitoring only.

[xxxv] Board District Annual Plan 2012/12

[xxxvi] *"The Integrated Care Collaborative (ICC) is a pan health sector approach to looking at how and where services are delivered, and developing more cost effective and client centred approaches to improved personal and population health outcomes."*

Improved Population Outcomes: By contracting via the PHO reporting could be consolidated into one report and a clearer picture of populations receiving services and changes in outcomes monitored.

This ICC program represents another shift in Board strategy, as well as yet another framing of principles, this time giving greater prominence to quality and safety. The 2012/13 Statement of Intent places considerable emphasis on the ICC projects and the impacts that process is intended to have on the Board's activities[xxxvii]:

where in the continuum the projects will have a positive and sustainable impact around achieving better, *sooner and more convenient health outcomes*:

Table 4

ICC Project Integration

	Number of Admissions	Length of Stay	Patient Outcome s	Primary Care Activity	HHS Outpatient Communit y Activity
Acute Demand & After Hours	▼	▸	▲	▲	▸
Long Term Conditions	▼	▸	▲	▲	▼
Communication between Primary and Secondary Care	▸	▼	▲	▸	▼
Health of Older People	▼	▼	▲	▲	▸
Child Health Action Plan	▸	▸	▲	▲	▸
Mental Health Commissioning Group	▸	▸	▲	▸	▼

Table 4 indicates the Board's hopes for the ICC projects. They will reduce acute demand, reduce admissions for Long Term Conditions, reduce the impact on the health of older people, and, in four of the six projects, increase primary care activity.

There is little made in the SOI between these anticipated outcomes, and the Board's current direction of reduced primary care investment, and increased planned and unplanned admissions.

The SOI also attempts to link the Government's and the Board's goals:

[xxxvii] 25/06/12 Board – C&CDHB Statement of Intent

The diagram below shows the value chain of how the outputs C&CDHB delivers have an impact on the health of the district's population and result in achievement of the long term outcomes and priorities of C&CDHB and Government. Each layer of this diagram contributes to the next layer up. The relationships are complex and not necessarily one to one.

Table 5 Value Chain

Government Goals & Health Targets	**New Zealanders living longer, healthier, and more independent lives**					
	Shorter stays in emergency departments	Improved access to elective surgery	Shorter waits for cancer treatment	Increased immunisation	Better help for smokers to quit	More heart and diabetes checks
CCDHB Strategic Goals and Priorities	**Better health and independence for our people, families and communities**					
	Reducing disparities	Improving the health of children in vulnerable communities, with a particular focus on rheumatic fever, serious skin infections and respiratory conditions	Ensuring clinical engagement in the planning and development of services	Living within our means	Achieving the Minister's health targets and expectations	Collaborating with other regional DHBs to improve service delivery efficiencies
Population health outcomes	Reduced disparity	Risk factors minimised	Improved child health	Long term conditions managed	People live well in own homes	Access to integrated, sustainable, quality services
Impacts	People reduce risk behaviours and adopt healthy lifestyles	People take steps to protect the health of themselves, their families & community	People are managed in the community & avoidable admissions are reduced	Oral health status is improved	People with long term conditions are engaged with & supported by health services	People receive prompt acute care in the Emergency Department	Access to elective surgery is increased	Cancer mortality is reduced through timely treatment	Support for older people living at home is improved and integrated
Output Classes	Prevention Services		Early Detection and Management		Intensive Assessment and Treatment		Rehabilitation and Support	
Outputs	• Health promotion and education services • Population based screening services • Immunisation services		• Primary health care services • Oral health services • Pharmacy, laboratory & diagnostic services • Community mental health services		• Medical & surgical services • Cancer services • Maternity services • Mental health services		• Needs assessment & service coordination services • Home based support services • Residential care services • Palliative care services	

Table 5 does not appear to be a value chain.[xxxviii] Instead it is a valiant attempt to reconcile the Board's intervention logic with the Minister's specific targets.

The Minister's targets are "outputs" in the diagram, at the very bottom of the Value Chain. This is shown in Table 6, where the Minister's targets in bold have been placed within the Board's outputs. Another difficulty for the Board is that the Minister's targets are hospital focused, with four of the six targets relating to "Intensive Assessment and Treatment" and none for rehabilitation and support. The impact of this is that higher priority is given to a small subset of outputs and the Board's broader objectives, further up the value chain, are lost.

Table 6 Minister's targets embedded with Board's outputs.

	Prevention Services	Early Detection and Management	Intensive Assessment and Treatment	Rehabilitation and support

Outputs	• Health promotion and education services
	• Population based screening services
	• **Immunisation services**
		• Primary health care services
		  ○ **Heart and diabetes checks**
		•
		• Oral Health Services
		• Pharmacy, laboratory, &diagnostic services
		• Community mental health services
			• Medical and Surgical Services
			  ○ **Stay in ED**
			  ○ **Access to elective surgery**
			• Cancer Services
			  ○ **Waits for cancer**
			  ○ **Help for smokers to quit**
			• Maternity Services
			• Mental Health Services
				• **Need assessment & service coordination services**
				• **Home based support services**
				• **Residual care services**
				• **Palliative care services.**

The illogical nature of the SOI's "Value Chain" is not due to the complexity of the issues, but to the incongruity of a Government targeting mechanism that has given undue emphasis to highly specific outputs by the Minister causing many of the Board's objectives to effectively wither on the vine of accountability.

In December 2012 and January 2013, the Board held its key strategic meetings for the 2013/14 year. The papers were not released under the OIA request as they:

> *Contain information that is likely to prejudice or disadvantage activities and/or negotiations so has not been released to the public*

[xxxviii] http://www.tutor2u.net/business/strategy/value_chain_analysis.htm Value Chain Analysis describes the activities that take place in a business and relates them to an analysis of the competitive strength of the business. Influential work by Michael Porter suggested that the activities of a business could be grouped under two headings: (1) **Primary Activities** - those that are directly concerned with creating and delivering a product (e.g. component assembly); and (2) **Support Activities**, which whilst they are not directly involved in production, may increase effectiveness or efficiency (e.g. human resource management).

What evidence is there of the impacts of these decisions on hospital services and effective use of primary health care?

To answer this question two sets of data have been reviewed: unplanned hospital admission data in general, and ASH data in more detail. Both are indicators of primary health care performance.

Unplanned admissions

Unplanned admissions[11] are admissions that are not predicted and happen at short notice because of perceived clinical need .They may indicate inefficient use of health services, particularly if the health condition precipitating the admission could have been effectively dealt with in the community.

Figure 3: Unplanned admissions C&CDHB (OIA)

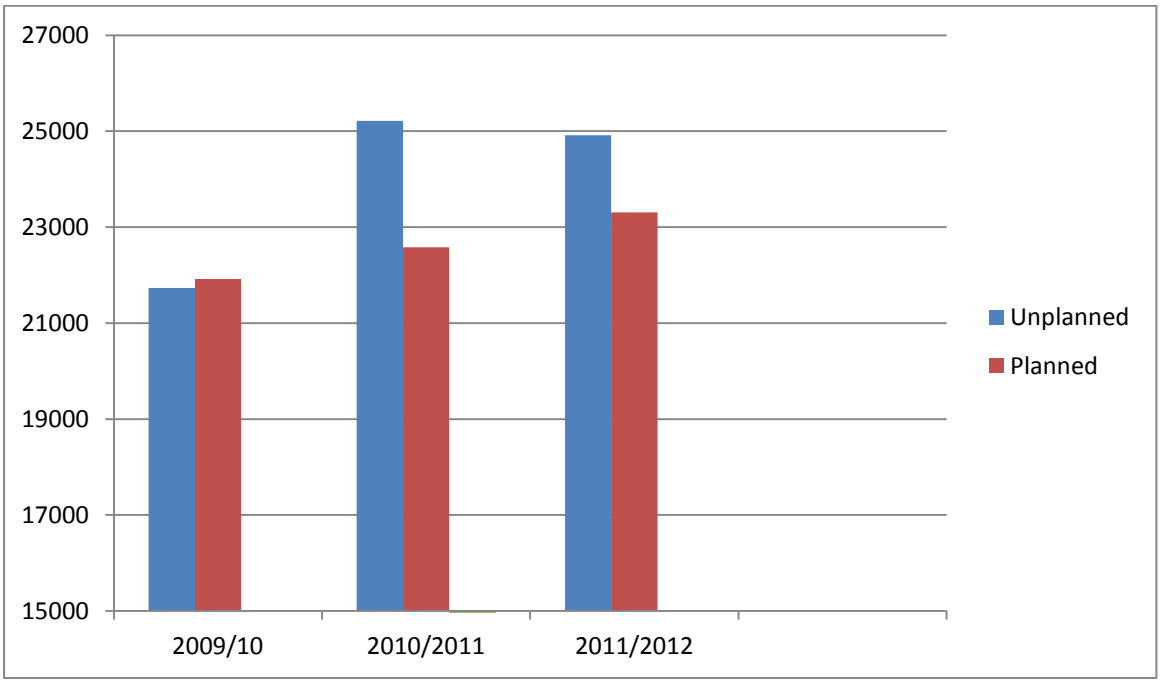


Figure 3 shows that unplanned admissions rose significantly (16 percent) in 2010/11 and remained high for the following year. These 3,380 extra unplanned admissions (between 2009/10 and 2010/11) cost approximately $15 million[xxxix] to provide.

The drivers of this change are likely to be due to multiple causes, including changes in demand and supply factors. However, it does suggest that the Board's narrow focus on cost

[xxxix] At estimated cost of $4,000 an admission.

containment, coupled with growth of electives, is resulting in a potential decrease in the efficiency with which its resources are being used.

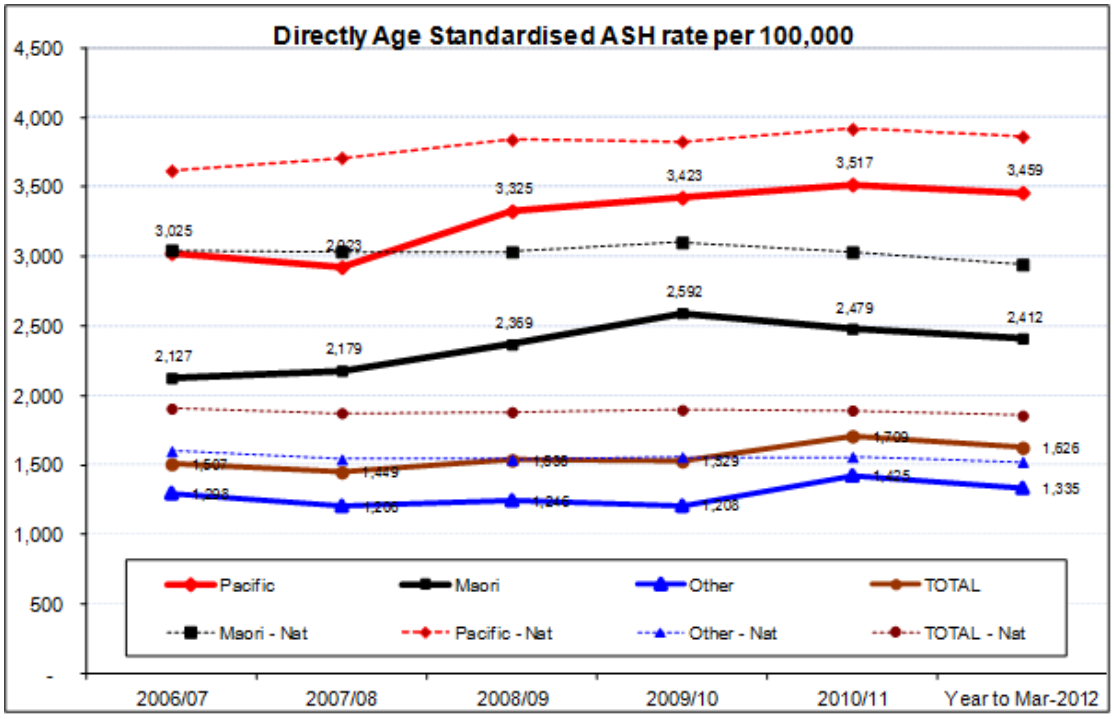
A more precise indicator to explore the effectiveness of primary health care at its interface with the hospital is ASH.

Ambulatory Sensitive Hospitalisations

ASH is a composite measure of the performance of the primary health care system, and primary care's impact on access and equity in health services. Almost all ASH admissions to hospital are unplanned and are potentially preventable by appropriate health services being delivered in community settings, including through primary health care (and hospital ambulatory services, eg outpatients and dental services). ASH rates provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

Figure 4 represents the ASH rates in the age groups 0–74 years for different ethnic groups in the C&CDHB.

Figure 4: ASH trends by ethnicity comparing national and C&CDHB for 0–74 years



The most important point is the persistent level of inequity in access to care for Pacific and Māori, who experience 2 to 3 times the rate of ASH as other ethnic groups. This degree of disparity is similar across the country (dotted lines) with C&CDHB performing better than the national average. However, the trends suggest a deterioration in C&CDHB performance in

2010/2011 with rates well above its best performance in the 2007/08 year. This drop in performance is most marked for Māori and Pacific populations.

The two indicators, unplanned admissions and ASH, show a deterioration of C&CDHB performance, moving closer towards the national average. Of most significance is the persistent gap in ASH rates between ethnicities that has not been closed over the period of this review and remains a major challenge for the New Zealand health system, including C&CDHB.

Discussion:

This window into the C&CDHB's decision making raises a number of issues for further exploration.

The first issue is the lack of control the Board has over decentralised functions such as primary health care. On the one hand the Board is seen as responsible: on the other the majority of the funding decisions are being taken outside of its jurisdiction, by the Minister or the National Health Board. In C&CDHB's case, it had invested in primary health care, it had provided evidence of the effectiveness of this investment; however, as soon as financial pressure was asserted, it dismantled the very services that were contributing to its high performance, as this happened to be the only part of primary health care funding over which it had authority.

At a more fundamental level, this account shows the losing struggle by the Board to keep a focus on equity. As noted by the ASH statistics, the status quo is highly inequitable, with long-standing access problems for Māori, Pacific and low income people. The Board's empowering legislation is unequivocal on this point[9]:

> *to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders*

The Board maintained equity as a high level goal, but increasingly failed to take operational decisions consistent with this goal as they attempted to live within their means.

A number of factors contribute to this failure of purpose. The use of highly specific targets focused on small parts of the Board's business increasingly undermined the non targeted areas, crowding out the Board's ability to solve more complex problems such as equity. Although equitable delivery of the targets has benefit (such as high immunisation rates), success in these areas is insufficient to address broader systematic inequities such as the

lack of accessible, affordable primary health care services. This shift in focus away from equity is further reinforced by the removal of any reporting on trends in equity from annual reports on Implementing the New Zealand Health Strategy[12]. In addition, in political economy terms, addressing equity is not the main priority of the more powerful stakeholders in the Board's domain, such as the hospital and the mainstream PHOs. Even between these two it is not an even playing field, with the Board being both funder and provider of the hospital services, whereas it provides only funding support for the primary care sector, which also has the ability to shift costs on to patients. It is no accident then that the net result has been to grow the hospital sector, in response to the focus on electives and targets, at the expense of the Board's stewardship role over the whole sector and pursuit of equity. In the Board's own words, its stewardship role is reduced to "*An organisation configured to achieve health targets."*

Another lesson from this account is how these high level policy tensions played out within the Board's decision making and operational processes. The changing "Principles" reflect an organisation struggling to marry conflicting instructions. There is also inconsistent use of evidence, particularly about equity. The lack of follow-up of stated intentions to report on the outcomes of decisions is a concern.

The operational response reflects continued confusion, with cost saving and efficiency being placed alongside equity as though they were competing goals. They are not. The pursuit of equity is a high order goal of a public health system, irrespective of the funding environment, which in all likelihood will continue to be restrained. It is a goal that needs effective strategies.

The C&CDHB has been one of the higher performing Boards in New Zealand in primary health care and population health gain. In his classic text[13] author James C Collins coined the phrase "Good to Great" to describe the characteristics of successful companies. This review suggests the performance of C&CDHB is moving from "Great to Good" as it struggles, with reduced funding, "to live within its means". The recent strategy change, ICC, with its stated intention to improve health and equity for all populations, reduce admissions, and increase primary health care activity would mean a reversal of the Board's current trajectory. It too will be unlikely to be successful unless the national settings for the health sector change and the Board has the decision -making space to invest strategically in primary care and prevention.

Appendix 1:

Questions asked under the OIA

1. Please provide comparable figures tracking expenditure by the DHB from 2007 to 20012 in the following categories:

Total DHB expenditure.

- Hospital Expenditure
- Other Community Services (DSS, MHS, Dental)
- Referred services
- Primary Health
- Governance

2. Please provide a detailed rationale, including the expenditure by item, for the 18% increase in expenditure on Board "Governance" as described in you Statement of Intent.
3. Please provide the policy documents, strategic papers, issues papers, prioritisation frameworks presented to the Board, the CEO or the Executive team where the background or justification was made to the decisions to increase hospital expenditure and decrease primary health expenditure. This relates to any of the years 2009 to 2012. Please include all policy papers presented which discussed funding options and prioritisation, including those that were not subsequently adopted as Board policy.
4. Please provide the policy documents, strategic papers or issues papers, presented to the Board, the CEO or the Executive team where the background or justification or consideration or analysis was undertaken on the impact of funding changes in primary health on high need populations. This relates to any of the years 2009 to 2012. It includes all papers presented which discussed funding options for primary care, including those that were not subsequently adopted as Board policy. This request includes any modelling that was undertaken of the likely impact of different expenditure scenarios. It includes (but is not restricted to) the documents leading up to the 2011/12 agreed savings plan, documents supporting the Board's decision to reduce the level of "Improving Access" funding, the "in depth service review" and "Value for Money Assessment" referred to in the issues paper of 24th July 2012.

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