

Affidavit of

**David George
Lambie**

**Under the Health and
Disability Services Act 1993**

**In the matter of the
Ministerial Inquiry into the
Under-reporting of Cervical
Smear Abnormalities**

**UNDER THE HEALTH AND DISABILITY SERVICES
ACT 1993**

**IN THE MATTER OF THE MINISTERIAL INQUIRY
INTO THE UNDER-REPORTING OF CERVICAL
SMEAR ABNORMALITIES**

AFFIDAVIT OF DAVID GEORGE LAMBIE

MINISTRY OF HEALTH

I, **DAVID GEORGE LAMBIE** public servant of Wellington swear as follows:

INTRODUCTION

1. I am presently the Deputy-Director General, Corporate, in the Ministry of Health. In this position, which I have held since June 1997, I am responsible for the planning and financial management in the Ministry of Health, for the range of support services (including human resources, legal, facilities, communications, and information services) and for the Ministry's business units - the New Zealand Health Information Service, the National Radiation Laboratory, and MedSafe which is responsible for safety of drugs and medical devices.

2. I have been employed in various management roles in the Ministry of Health over the last 10 years, including positions in which I was responsible for monitoring service performance of the Area Health Boards (1990-92) and then the Regional Health Authorities (1992-95). Details of these previous management positions are as follows:

December 1995 to June 1997	Assistant General Manager (Strategic) Ministry of Health, Wellington Strategic health policy advice by the Ministry.
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November 1992 to August 1995	Manager, Performance Monitoring and Review, Ministry of Health, Wellington Analysis and reporting on performance of the Regional Health Authorities and the Public Health Commission in terms of their funding agreements with the Crown (financial and management performance and service delivery).
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February 1990 to November 1992	Manager, Area Health Board Performance, Department of Health, Wellington Monitoring of service performance of the Area Health Boards in terms of their contracts with the Crown.
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3. I have academic qualifications in biochemistry (BSc and PhD), economics, and information management. Prior to joining the Ministry of Health I was for 10 years a research scientist (at the Institute of Neurological Sciences, Glasgow and the Wellington Clinical School of Medicine of the University of Otago). I also spent 5 years as a policy advisor and economist with the Department of Scientific and Industrial Research (DSIR).
4. This evidence has been prepared in response to questions raised by the Inquiry Panel about the negotiation of funding agreements and the monitoring of performance under those agreements. These are functions of the Performance Management Branch of the Ministry. As well as my own experience with Performance Monitoring, I have consulted with and rely upon the present Director of Purchase Interest within the Branch, Ms Joan Mirkin, who was involved in funding contract negotiations. I have also overseen a further search of Branch files for any documents which might be relevant to negotiations and monitoring issues for the National Cervical Screening Programme, or relevant laboratory services.
7. This evidence covers the Crown's accountability arrangements with key health sector agencies (funders and purchasers) during the period 1990 to the present day and addresses issues raised by the Inquiry Panel. It provides a broad overview of how these essentially governance level accountability processes worked as well as some more specific points in relation to cervical screening. This material is presented in three sections:
 - 7.1 Some background to the 1993 Health Reforms;
 - 7.2 Funding Agreement negotiations; and
 - 7.3 Monitoring issues.
8. The accountability arrangements described in this brief of evidence relate primarily to the governance of those agencies, rather than to the operation, monitoring and evaluation of health programmes such as the

National Cervical Screening Programme (“NCSP”). The overall monitoring of health programmes and the evaluations of the effectiveness of the underpinning policies is the responsibility of the Ministry’s relevant policy branches. The Health Funding Authority (“HFA”) took over the responsibility for monitoring the NCSP when the National Co-ordinator and Register were transferred from the Ministry to the HFA in April 1998. Since July 1993 the Regional Health Authorities (RHAs) had responsibility for the operation of the Programme in terms of their contracts with service providers. However, there are overlaps between the responsibilities of those monitoring agency performance and those monitoring and evaluating health programmes.

9. It should be noted that the structure of what is now called the Performance Management Branch has changed a number of times between 1990 and the present time. For simplicity I am using the term Performance Management Branch, but in fact this branch has only been in existence with its current name and structure for 18 months (since October 1998). Prior to that the functions were split differently and the units responsible for those functions had different names. However, the roles have remained fundamentally the same and it might be confusing to try and differentiate these in this evidence.
10. Similarly, since 1990 the health sector has been funded (in part or, more recently, in full) through 14 Area Health Boards, four RHAs, a Public Health Commission, a Transitional Health Authority and a Health Funding Authority:

1990 - June 1993	14 Area Health Boards (these entities did not fund primary health services, including diagnostic services provided by, for example, community laboratories, which were funded by the Department of Health under the various “health benefits” schemes)
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1993 – 1997	4 Regional Health Authorities <ul style="list-style-type: none"> • established 3 June 1993 (SR 1993/145) • disestablished 2 July 1997 (SR 1997/99)
1997 to the present	Transitional Health Authority (established 16 April 1997 (SR 1997/57) and renamed the Health Funding Authority (1 January 1998 (SR 1997/312))

12. For the sake of simplicity I generally use the term RHA to describe all of these agencies.
13. From 1993-1996 there was also a Public Health Commission with responsibility for the health promotion aspects of the cervical screening programme. These responsibilities were transferred to the RHAs when the PHC was disestablished on 22 January 1996.

PART 1: THE HEALTH REFORMS OF 1993 - SOME BACKGROUND

14. One of the key changes introduced by the July 1993 reforms of the health and disability sector was the creation of a “funder/purchaser/provider split”.
15. The funder/purchaser/provider split introduced a separation between the roles and functions of:
- 15.1 the Crown, as **funder** of the publicly funded component of the health and disability sector
 - 15.2 the regional health authorities (created by the Health and Disability Services Act 1993) as **purchasers** of services
 - 15.3 **providers** of health and disability services:
 - 15.3.1 primary care services (including general practice, pharmacies, laboratories and independent mid-wives);

- 15.3.2 secondary and tertiary (hospital) services;
 - 15.3.3 public health services (including health promotion, healthy environments and disease prevention and control);
 - 15.3.4 disability support services (rest homes, home support services, day services etc).
16. In brief, the policy intentions of these changes introduced by the Act were as follows:
- 16.1 to create an environment that would deliver the best health outcomes for the funding provided. This included provisions for establishing the RHAs that would analyse and address all the health and disability support needs of the whole of the regions covered by those arrangements;
 - 16.2 by removing purchase responsibilities, to free up the boards and management of publicly owned hospitals so that they could focus on the complex task of operating their hospitals;
 - 16.3 to remove the conflict of interest faced by area health boards in both reshaping health services in their regions (in promoting health promotion and prevention initiatives for example, with a focus on primary health care to keep people out of hospitals) and ensuring enough “business” to keep their hospitals viable clinically and financially.
17. In the introduction to the Branch’s Review of 1994/95 RHA contracting at p.15 the authors note as follows:

“In the past there has been a variety of payment arrangements in place for health services, with relatively little specification or accountability. Hospital services were paid for by bulk funding of hospital boards and, more latterly, area health boards. There was little specification of the services to be provided and a lack of accountability for their provision, under these historical funding arrangements.”

In the primary care and disability support service areas, payment has traditionally been made on an open-ended fee-for-service basis, often according to regulations. Expenditure on these unconstrained demand driven service areas has grown rapidly, well ahead of demographic growth, particularly in maternity and primary referred services. Percentage fee increases were often awarded across the board. These transaction or event-based payment systems required little accountability. GPs, for example, as 'gate-keepers' of access to a number of services, were not required to account for their prescribing and referral practices.

Other independent service providers and voluntary agencies have received grants, often for services with limited specification and little accountability. Little dialogue was entered into between funder and provider about the appropriateness of how these services were provided in relation to the needs of service users.

The new environment was to provide the flexibility to change this situation. The split of purchaser and provider functions was expected to increase the effectiveness of health service provision by enabling more explicit needs-based purchasing; and to provide better value for money in service provision, through the increased efficiency expected as a result of competition being introduced to the sector.

One of the predicates of the reformed system is that greater specification of what is purchased is a good idea. Contracts are seen as levers for increased specification and increased accountability. Through the leverage afforded by contracts, there is an expectation of a greater ability to influence the mix, level, quality and quantity of services provided, and to have them provided for the right price. In turn, this is expected to allow for greater accountability, translating into increased public assurance through greater transparency.

It was also anticipated that different patterns of service provision would emerge, with horizontal and vertical expansion of service provision by existing providers (for example, extended general practice and secondary care budget holding), and the entry of new providers (for example, private hospitals).

Reconfiguration of existing markets and the challenging of historically protected patches was expected to lead to greater efficiencies and less excess capacity (for example in the laboratory services area with its somewhat artificial distinction between hospital and private community laboratory services, and where there is considerable excess capacity).

The ability of regional health authorities to make linkages and trade-offs across services at a regional level was to be an

added advantage of the reformed system expected to lead to needs based, and more transparent purchasing decisions.

In previously input funded areas, such as primary care, it was anticipated that there would be a shift to the purchasing of outputs.

All of these expectations had a common feature – they were to be brought about through contracting with providers.”

18. A copy of the Review and its appendix are exhibited to this affidavit as **DGL/MOH/0001** and **DGL/MOH/0002** respectively.
19. At an operational level, the same people in the Ministry of Health had programme co-ordination functions for the NCSP after the launch of the reforms and the National Co-ordinator of the NCSP maintained the national operational relationship with the staff of the Crown Health Enterprises. People in the Department of Health who had responsibility for negotiating and monitoring contracts with the area health boards had similar roles in the Ministry in relation to the regional health authorities.

PART 2: FUNDING AGREEMENT NEGOTIATIONS

GENERAL

20. The Funding Agreement is the annual contract between the Crown (represented by the Minister of Health) and the four RHA boards. The Performance Management Branch has been the agent of the Minister in negotiating a Funding Agreement with the RHAs. I understand the Agreements are in evidence before the Inquiry.
21. Whilst the nature of the funding agreements has changed over the years since 1993, the following principles have remained constant:
 - 21.1 within the Ministry the policy branches are the “principals” in the negotiations with the RHAs. The Performance Management Branch is the “agent” of the policy branches;

- 21.2 what is negotiated needs to be able to be delivered within the funding available for the year.
22. In practice, this meant that the Ministry's policy branches would first identify key issues or initiatives that would need inclusion within the Funding Agreement. The Performance Management Branch would then negotiate with the RHAs about the inclusion of these matters in the Funding Agreement, taking account of the Government's priorities and what could be realistically delivered and measured.

CONTENT OF FUNDING AGREEMENT

23. The main elements of the Funding Agreement are:
- 23.1 service cover i.e. a description of the range of services to be funded, the terms of access to those services, the quality of services and any charges or user co-payments;
 - 23.2 performance indicators for key priority areas and how these will be monitored;
 - 23.3 an operating environment which sets some constraints on the purchaser/funder;
 - 23.4 information provision requirements.
24. In addition, while the sector was split into 4 RHAs (1993/94 to 1996/97), each RHA Funding Agreement contained a customised part which outlined, for that RHA, how it intended to give effect to the health gain priority areas, its plans for new service initiatives and process initiatives, service changes, contracting strategies and risk management strategies, its funding and its budgets for the year. The customised part also outlined the targets to be achieved for each of the performance indicators.
25. The negotiation process involved the following:
- 25.1 development of the common part of the Funding Agreement;

25.2 development of the customised part of the Funding Agreement.

DEVELOPMENT OF THE COMMON PART OF THE FUNDING AGREEMENT

26. Branches in the Ministry were asked to identify any new policy or changes needed to the existing Funding Agreement. This was done through a Ministry wide process of developing a document called the *Policy Guidelines*¹ which were approved and issued by the Minister.
27. Copies of the Policy Guidelines documents are exhibited to this affidavit as follows:
- 27.1 Policy Guidelines to RHAs, November 1992: **DGL/MOH/0003**;
- 27.2 Policy Guidelines for RHAs 1994/95: **DGL/MOH/0004**;
- 27.3 Policy Guidelines for RHAs 1995/96: **DGL/MOH/0005**;
- 27.4 Policy Guidelines for RHAs 1996/97: **DGL/MOH/0006**.
28. This document then became the basis for the negotiation around the funding agreement, i.e. the Funding Agreement represented what the parties agreed was realistic/feasible and measurable for RHAs to implement in a given year and for which the RHA would be held accountable for delivering.
29. The Ministry sent a first draft agreement to the RHAs and discussions and negotiations commenced around what was achievable within the funding appropriated for the year.
30. Negotiations with individual RHAs and joint RHAs (the four RHAs) took place, both face to face in meetings and in writing. Negotiations involved the policy branches, Performance Management Branch and RHAs in the decisions about priorities.

¹ The first *Policy Guidelines* was not able to build on previous Funding Agreements and was developed by pulling together the key policy settings of the day.

31. Central agencies were consulted on the draft agreements and given the opportunity to provide feedback. These included Te Puni Kokiri, Ministry of Women's Affairs, Ministry of Youth Affairs, Ministry of Pacific Island Affairs, the Treasury.
32. Records were kept of the written feedback from each RHA, Ministry branches and external central agencies. Some examples of responses are provided for your information including comments from the Ministry of Women's Affairs, RHAs and internal Ministry comment relating to cervical screening. The records include Performance Management Branch's responses to Ministry and agency feedback and the reasons for those responses. These documents are exhibited as a bundle in chronological order as **DGL/MOH/0007**.
33. The Funding Agreement was approved by the RHA Boards and then signed by their Chairs and the Minister.
34. At key points during the process, the Performance Management Branch briefed the Minister on progress in the negotiations and on the key issues under consideration.

DEVELOPMENT OF THE CUSTOMISED SECTION OF THE FUNDING AGREEMENT

35. As noted above, there was a negotiated customised section of the Funding Agreement for each RHA (for 1993/94 to 1996/97) which outlined in more detail its purchase intentions. The process for developing this section included the following:
 - 35.1 early in the Funding Agreement process, RHAs provided strategic purchase presentations to the Minister of Health to give the Minister and officials an early insight into the RHA purchase intentions for the following year;
 - 35.2 RHAs developed detailed purchase plans, usually focusing on health gain priority areas, new service initiatives and process initiatives, service changes, contracting strategies and risk

management strategies etc. The plans also included responses to particular areas of interest outlined in the *Policy Guidelines*;

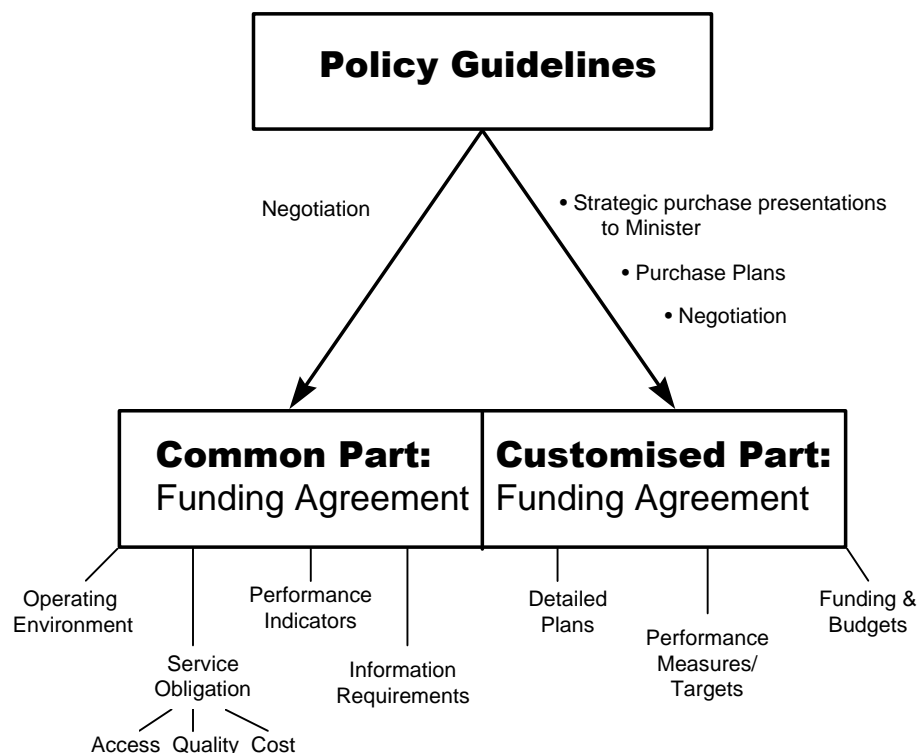
35.3 these purchase plans became the basis for the customised part of each RHA's Funding Agreement and were negotiated with RHAs;

35.4 the customised part of the Funding Agreements also included the specific performance measures and targets signed up to by each RHA (developed within the framework of performance indicators established in the "core" Funding Agreement);

35.5 ongoing input was sought from policy branches of the Ministry, but not external agencies (which had been involved in setting the general parameters) during the negotiation process.

36. The Funding Agreement components and processes are shown diagrammatically below:

Funding Agreement Process



THE CONCEPT OF “REASONABLE ENDEAVOURS”

37. A feature of all but the more recent Funding Agreements was the use of the words “reasonable endeavours” and “best endeavours” to qualify many of the Service Obligations.
38. In the first year (1993/94), the level and quality of services that each RHA was required to purchase was the same as that which eligible people had access in 1992/93.
39. In the following year (1994/95), the Ministry and RHAs faced the following issues in relation to negotiating and agreeing a set of minimum service obligations:
- 39.1 the RHAs had inherited an historical pattern of service delivery which was patchy across the country. In some areas, the service obligations were already being met (or exceeded) and in other areas they were not. The volume of services (and the per capita funding) in the north of the country was historically lower than in the south;²
- 39.2 the RHAs needed time to be able to manage the redistribution and expansion of services to be able to comply fully with these service obligations;
- 39.3 the population based funding formula was to be introduced gradually over a period of years to ensure an equitable basis for funding RHAs and, consequently, equitable access to services across the country. This approach would move the funding from the south (which was overfunded relative to the north on a population basis).³

² Purchasing for Your Health 1994/95 (page 20, Appendix1 (v))

³ With the establishment of RHAs, the emphasis for funding was on regional needs rather than on individual services; and on equitable funding across the country. Population-based funding formulae (PBFF) were developed for Personal Health, Public Health, and Disability Support Services funding. These PBFF determined the relative shares of funding for each RHA (based on population demographics and other relevant factors). During 1994/95, Northern and Midland RHAs gained increased funding to address historical imbalances and move towards more equitable funding nationally. (Purchasing for Your Health 1994/95, Personal Health Funding Formula 1996/97)

40. Given that the RHAs were required to purchase services within the funding appropriated, it would have been inappropriate to have expected RHA Boards to have signed a fully prescriptive Funding Agreement where there were likely to be some service areas where they knew they would not be able to fully comply.
41. Equally, in relation to the range, volumes and quality of services, it would have been detrimental to the health and independence of New Zealanders to have reduced the service obligations to the lowest common denominator. As a result, for most services, the terms “reasonable endeavours” and “best endeavours” were used. “Best endeavours” was considered to require a higher degree of effort; almost a mandatory requirement.
42. There were some service areas where there was agreement that the concept of “reasonable” or “best” endeavours was not sufficient and in these cases the Ministry negotiated “absolute” requirements with the RHAs.

THE MOVE AWAY FROM “REASONABLE ENDEAVOURS” AND “BEST ENDEAVOURS”

43. With increased funding going into the health sector⁴ and completion of the move to population based funding (the shift to equity), the RHAs had an increasing ability to shift funds into areas of higher priority and made ongoing progress towards being able to meet the service obligations. At the same time, there was a convergence of view between the RHAs and the Ministry as to what was achievable, rather than what was considered ideal, and in 1997/98 all of the service obligations became absolute.

⁴ Funding over time (New Zealand)

	1986/87	1993/94	1996/97
Nominal funding (\$B)	2.942	4.426	5.25
Nominal funding per capita (\$)	895	1267	1438
Real funding (\$1996/97) (\$B)	4.448	4.785	5.25
Real funding per capita (\$1996/97) (\$)	1354	1370	1438

Note: Excludes capital and transfers, includes CHE deficit financing
 Source: Health Expenditure Trends in New Zealand 1980-97

THE RELATIONSHIP BETWEEN THE *POLICY GUIDELINES* AND THE FUNDING AGREEMENT

44. It has been noted in previous evidence that the *Policy Guidelines* in 1994/95 contained on their face absolute requirements in relation to the cervical screening programme, and particularly the requirement for TELARC registration of laboratories, and that this became “reasonable endeavours” in the Funding Agreements. There may have been negotiation around this issue.
45. The *Policy Guidelines* were designed to collate in one document, new and existing health and disability policies and to form the basis of the negotiations between the Crown and the RHAs. It was not a document that had legal status although it was widely distributed to the sector with an accessible style, to ensure a broad understanding in the sector of Government’s policy directions and expectations of the RHAs. The Funding Agreements on the other hand were negotiated contracts (which being complex legal documents, are somewhat less accessible to the lay reader).
46. The Funding Agreement negotiation process put the *Policy Guidelines* into the context of the amount of funding appropriated to each RHA. The Funding Agreement represented an agreement about the range of services to be purchased, This involved debate and negotiation between the parties about trade-offs and priorities. As a result the Funding Agreement was not always identical to the *Policy Guidelines*. In addition, while the broad range and level of services to be purchased was described in the Funding Agreement, individual RHAs determined the detailed service mix for their regions, based on such factors as need and availability of services and any minimum access criteria specified in the Funding Agreement.
47. A key feature of the *Policy Guidelines* was their focus on new policy implementation. They were not designed to describe the totality of all of the policies to be implemented and services to be purchased by the RHAs (“business as usual”), or the resource implications of the total package.

This approach was reflected in the Funding Agreements where the balance between new policy and business as usual was weighted heavily towards new policy in terms of the level of detail of the expectations of the parties to the Agreements.

THE PUBLIC HEALTH COMMISSION

48. The Performance Management Branch was also responsible on the Ministry's behalf for negotiating and monitoring Funding Agreements with the Public Health Commission during the Commission's lifetime. This followed a similar process as for the RHAs. The Public Health Commission was responsible for the health promotion aspects of the cervical screening programme.

COMPENDIUM OF REFERENCES TO CERVICAL SCREENING OVER THE RELEVANT PERIOD

49. I attach as exhibit **DGL/MOH/0008** a summary of purchase arrangements for cervical screening services from 1990/91 to 1999/00, cross-referenced to the source documents. The document summarises the relevant statements in Policy Guidelines, the Service Cover and Monitoring Requirements in the Funding Agreements. Extracts from the source documents are also attached.

PART 3: MONITORING THE RHAS AND MANAGING THEIR PERFORMANCE

MONITORING FOR ACCOUNTABILITY

50. This discussion describes monitoring that was carried out for agency accountability purposes in addition to the more direct 'operational' monitoring within and of the cervical screening programme. For further detail of how the accountability monitoring and operational monitoring complement each other see paras.286-346 of Judith Glackin's evidence in chief.

51. The Ministry's approach to monitoring for accountability purposes is based on the premises that:
- 51.1 it should complement RHAs monitoring of contracts (i.e. it should focus on RHA performance, rather than provider performance (being the RHAs' responsibility) or sector performance);
 - 51.2 it should be efficient (i.e. it should address a sample of expectations in detail, rather than all of them (as is the case for financial audit, for example) and should draw on information generated by operational and management systems, rather than requiring system development to produce information irrelevant to others);
 - 51.3 it should be cost effective (i.e. it should find an appropriate balance between the resources needed for monitoring and other functions).
52. There are two key areas for Performance Management Branch monitoring:
- 52.1 delivery of service obligations by the RHA as laid out in the Funding Agreement; and
 - 52.2 delivery of new policy initiatives by the RHA.

MONITORING FRAMEWORK

53. The RHAs were required to deliver the service obligations and new policy initiatives as laid out in the Funding Agreement. A Monitoring Framework established the basis for the Ministry's monitoring of RHA performance. This document (revised from time to time) set out and described specific performance measures and detailed data definitions for specific indicators. The process for the selection of performance measures and indicators is discussed below.

54. The framework for monitoring service obligations indicated that the service obligations would predominantly be monitored by checking (on a sample basis) the purchase agreements negotiated between RHAs and providers to ensure the RHAs were seeking commitments from providers that would give effect to the expectations the Minister had of the RHAs. This was one of the issues examined in the August 1995 Contracting Review, discussed later in this affidavit. The RHAs' performance in assuring service delivery was also verified through the monitoring of national information systems or where robust information was supplied, via Funding Agreement information requirements.
55. In addition, the RHAs reported formally each quarter against performance indicators⁵ in the Funding Agreements.
56. Performance indicators were selected and defined in consultation with other branches of the Ministry and the RHAs. Performance indicators fell into two categories:
- 56.1 quantitative; and
 - 56.2 qualitative.
57. Quantitative measures were used to provide indicators of performance in ensuring service coverage under the service obligations. Measures were generally selected on the basis of:
- 57.1 the availability of information needed to evaluate performance; if the information needed fell naturally from existing management information or operational systems it would be more likely to be available in a timely manner, and to acceptable standards (of data quality);
 - 57.2 the ability of the RHAs to influence performance; and

⁵ In 1993/94 there were both "accountability" and "explanatory" indicators - the latter were indicators with no agreed performance targets that were used as the basis for establishing baselines for performance measurement in subsequent periods.

57.3 materiality.

58. Indicators included the following ‘quantitative’ indicators directly related to cervical screening:

58.1 colposcopy patients waiting >6 months;

58.2 colposcopy patients with CIN-3⁶ waiting > 4 weeks.

59. The RHAs also reported six-monthly on achievement against “qualitative” indicators, ie. areas where each RHA was required to agree objectives, specific to that RHA, for achievement. These indicators related primarily to new policy initiatives.

60. Qualitative measures were generally used where it was considered that expectations on RHAs could not be formulated in precise terms as “service obligations” since the “service obligations” related to business as usual. As such, qualitative measures were frequently devised to provide assurances about RHA performance in implementing new policy initiatives (breast cancer screening, additional mental health services, waiting times for elective surgery, child health and Māori health, for example)⁷.

61. Although there appears to have been some discussion about the fit of TELARC registration for laboratories providing services for cervical screening within the Funding Agreement (see **JMG/MOH/102**), expectations about TELARC registration were formulated as service obligations within the Funding Agreement rather than as specific performance indicators.

⁶ CIN-3 [Cervical Intraepithelial Neoplasia grade 3] refers to cytology coding for pre-cancerous high grade cell changes.

⁷ An example of the requirement for RHAs to develop qualitative indicators is exhibited as **DGL/MOH/0008-U**.

REVIEW ACTIVITY

62. Although the primary focus of the Ministry's monitoring of the RHAs performance was on their performance against the Funding Agreement (service obligations and performance measures), the Performance Management Branch set up a review programme to focus on key aspects of RHA performance to complement its ongoing monitoring of RHAs. Review topics were selected to cast light on the RHAs performance against their statutory functions or to address specific issues of interest or concern. Examples of reviews carried out under this umbrella include:
- 62.1 consultation processes;
 - 62.2 contracting, discussed further below;
 - 62.3 RHA's monitoring of the performance of provider contracts;
 - 62.4 specification of Funding Agreement expectations in relation to the responsiveness of providers to the needs of Māori;
 - 62.5 purchasing mental health services with "Mason" funding (Midland);
 - 62.6 financial and contract management systems;
 - 62.7 processes for evaluating the quality of services funded, discussed further below;
 - 62.8 management of the waiting times fund.
63. In August 1995 the Performance Monitoring and Review section of the Ministry of Health completed a *Review of 1994/95 RHA Contracting* ("the review"). This review aimed to identify whether the service obligations in the Funding Agreement were being translated appropriately by the RHAs into contracts with providers, to examine the strengths and weaknesses in contracting development and to recommend on aspects of contracting where improvements should be sought. Copies of the review and appendix are exhibits **DLG/MOH/0001** and **0002** to this affidavit.

The following part of this evidence concentrates on those aspects of the review which relate to cervical screening.

64. Part Three of the review assessed how well a selection of signed contracts with providers, deemed to be representative of services purchased by RHAs, complied with their 1994/95 Funding Agreements with the Minister. This included an assessment of how well RHA contracts with providers met the National Cervical Screening Programme requirements outlined in Part 10: sections 10.3 and 10.4 of the 1994/95 Funding Agreement. The review covered a sample of CHE and non-CHE contracts for primary care, disability support services and mental health services. The review only covered those services delivered under section 51 Notices⁸ that had been renegotiated and that had resulted in significant change for the 1994/95 year. Accordingly, no laboratory contracts were examined.
65. The review was not intended to comprehensively assess all of the RHAs contracts for cervical screening services but did find that RHA “Cervical screening contracts generally do not appear to cover the detail of the requirements set out in the Funding Agreement” (page 107 of the review). It found that while **some** of the requirements were located in **all** contracts, not **all** of the requirements of sections 10.3 and 10.4 of the Funding Agreement were clearly expressed in any of the contracts, at the level of detail expressed in the Funding Agreement (page 226, Appendix to the review).
66. The review recommended that “the contents of the report are noted and that RHAs address areas where they are not performing well in contracting and contract documentation” (page 12 of the review). To follow up this review, the Ministry conducted a review of the RHAs’ monitoring of the performance of provider contracts. Issues identified in

⁸ A section 51 Notice is a provision within the Health and Disability Services Act 1993: *S51- Arrangements relating to payments for health and disability services*. Under this provision RHAs can specify terms and conditions for payment of particular services. Acceptance of payment implies acceptance and compliance with the terms and conditions

the contracting review were also determinants in the selection of further review activity as identified above.

67. The Ministry's review of the RHAs' monitoring of the performance of provider contracts "found that RHA monitoring reflected the focus and state of the previous monitoring regimes ... [and] ... [t]here is a need, which all RHAs are addressing, to develop better monitoring processes."⁹
68. Last year the Ministry reviewed the HFA Quality Specification and Monitoring of Selected Services. A copy of the Report is exhibited as **DLG/MOH/0009** to this affidavit. It focused on four services being:
- 68.1 Accident and Emergency;
 - 68.2 Community Pharmacy;
 - 68.3 Crisis Response Mental Health; and
 - 68.4 Home Support.
69. The overall conclusion (see p.xvi) was that in the areas under review, there was no systematic monitoring of quality by the HFA (with the exception of community pharmacy) but that the changes underway were expected to lead to considerable improvements in quality monitoring.

OTHER REPORTS

70. In addition to information reported formally by the RHAs as part of accountability requirements, other information was used, analysed and reported for information purposes and national monitoring of health status. Examples of the annual publications, *Purchasing for your Health*, 1993/4, 1995/6, 1996/7. These are very substantial publications, copies of which can be made available to the Inquiry Panel if interested.

of the Notice. Four weeks notice must be given for any amendment or revocation. The Notice may be given individually or by public notice.

⁹ Cited in *Purchasing for Your Health 1994/95*, page 162, 163

71. Within the cervical screening programme, enrolment and mortality from cervical cancer have been tracked since 1990 and reported through the “Progress on Health Outcome Targets” publication. An extract of the report for 1998 is exhibited as **DGL/MOH/0010** to this affidavit. Within the Performance Management Branch background work was carried out to break down by RHA region the available information on enrolments, numbers of smears, detection of cervical cancer, and mortality from cervical cancer. An extract from an internal background report on Population Based Health Outcomes, dated June 1996 is exhibited as **DGL/MOH/0011** to this affidavit.¹⁰

PERFORMANCE MANAGEMENT: ESCALATING ISSUES

72. The corollary of monitoring the performance of the RHAs has been the need to address performance deficits. The following evidence describes the generic processes used by the Performance Management Branch to identify, then address, such performance deficits.
73. Issues of RHA performance (which might include concerns about provider performance) are brought to the attention of the Performance Management Branch either through:
- 73.1 formal reporting by the RHAs on the Funding Agreement performance measures and Ministry evaluation of those reports;
 - 73.2 monitoring of information from national information collections or provided by the RHAs;
 - 73.3 reviews carried out by the Performance Management Branch;
 - 73.4 information gained from the sector through a number of other sources such as:
 - 73.4.1 Ministry Chief Advisors and other Ministry staff;

¹⁰ Population Based Health Outcomes proposed a model for evaluating RHA performance on the basis of changes in health outcomes rather than on their performance in ensuring service delivery.

73.4.2 letters and approaches to Ministers and the Director-General by providers and consumers;

73.4.3 informal interactions with RHAs ;

73.4.4 analysis of information available in the sector.

74. Initial discussion with the RHAs on performance issues are through the Performance Management Branch (or, from time to time, in earlier years, through the Policy Branch staff) following up the issue directly with the RHA concerned. Many performance issues were able to be resolved through this follow up process.

75. Over time the way that issues have been escalated has been fairly similar (with some differences depending on the structures in place at the time). The list below captures these escalation mechanisms, in their usual order of application:

75.1 informal discussion, followed up in writing, between the account manager/portfolio manager and the person in the RHA responsible for managing the issue;

75.2 formal discussion, usually followed up in writing, between the Performance Management Branch manager to the appropriate manager in the HFA or the CEO of the RHA;

75.3 regular meetings between the Performance Management Branch Manager and senior staff and RHA CEO and senior staff,¹¹

75.4 reporting in the quarter report to the Minister;

¹¹ In RHA times, these meetings were usually quarterly and held with each RHA individually. The meetings were attended by senior Performance Management staff (sometimes accompanied by Policy staff if required) and the CEO and senior managers in the RHA. With the merger of the RHAs into the HFA these meetings have been replaced more recently by a regular weekly meeting between the Deputy Director-General, Performance Management and the HFA Chief Executive Officer. Issues requiring escalation are discussed at these meetings. Each week a message is sent out Ministry wide, asking for issues which should be escalated in this manner.

- 75.5 formal correspondence and/ or discussion between the Director General and the RHA CEO or Board;
- 75.6 formal correspondence and/or discussion between the Minister of Health and the Board Chair;
- 75.7 direction by the Minister under s25 of the Health and Disability Act 1993.¹²

MINISTRY RELATIONSHIP WITH PROVIDERS: INFLUENCING PROVIDER PERFORMANCE

76. Under the Health and Disability Services Act the RHAs, rather than the Ministry, had the direct, contractual, relationship with providers and were accountable for the services contracted for. The Ministry has, however, been able to impact significantly on provider behaviour through both the requirements of the Funding Agreement (agreeing expectations of the RHAs in relation to their contracting with providers), and also through its follow up activities with the RHAs. An example of this relates to colposcopy waiting times which have, from time to time, exceeded the required maximum times. Through active follow up with the RHAs, and ensuring that they address the issues with providers and report back on progress to the Ministry, the RHAs have ensured that providers have improved their performance. So, whilst the Ministry in most instances needs to work through the RHAs to influence providers, it has been able to do so successfully in many instances.
77. There are some instances where the Ministry has direct and formal interaction with providers over performance issues. This relates to the power of the Director-General under various statutes to conduct investigations into matters of concern. Examples of Inquiries commissioned by the Director-General include:

¹² A s 25 Notice has only rarely been used, as the escalation process usually results in resolution of issues. Uses of directions under S25 are:

- the provider of cardio-thoracic services in the South Island
- access to the beta interferons.

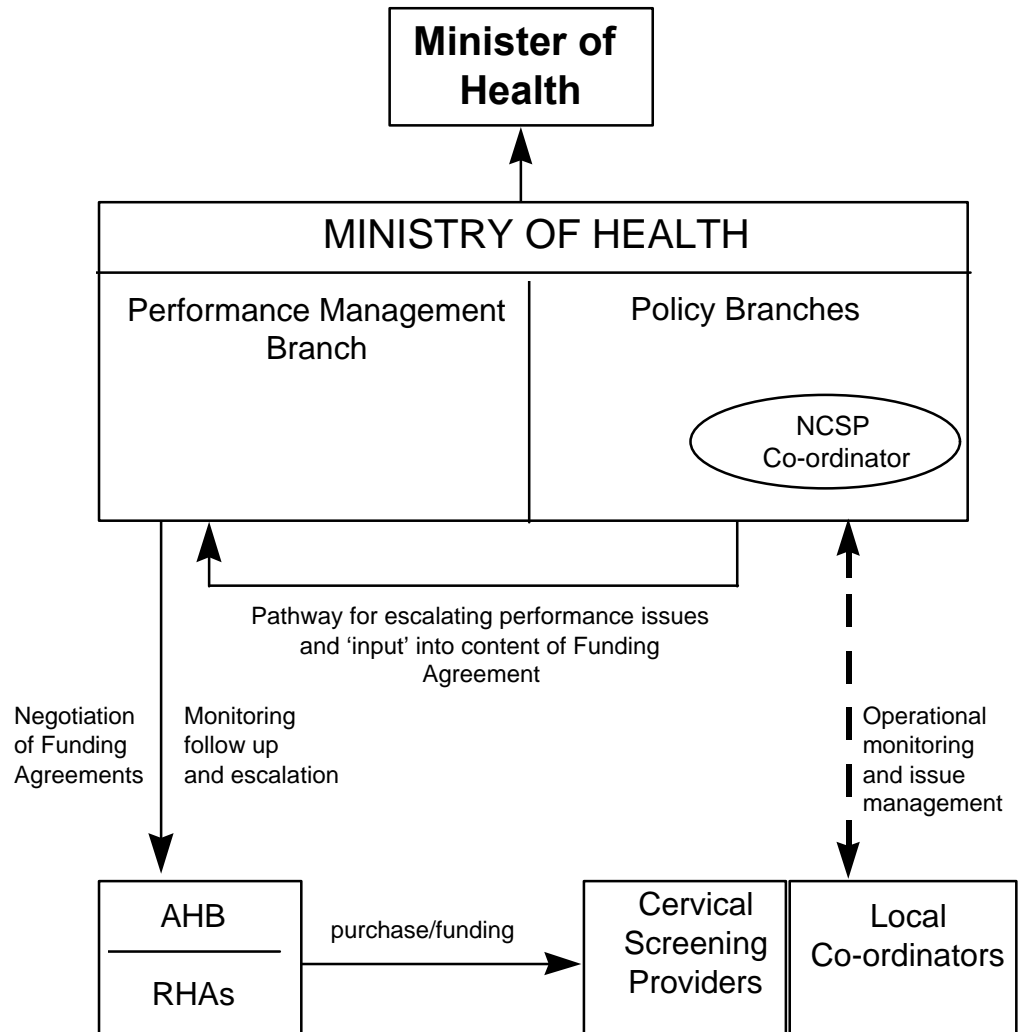
A direction was also used to define “Eligible People” for Funding Agreement purposes.

- 77.1 Inquiry into Possible Contravention of Regulation 19(b) of the Hospitals Regulations 1993; G R Boyd, C Deveson; July 1999.
- 77.2 Inquiry Under s.47 of the Health and Disability Services Act 1993 into the Provision of Chest Physiotherapy provided to Pre-Term Babies at National Women's Hospital Between 1993 and December 1994; Helen Cull QC, Dr Philip Weston, Jan Adams; July 1999.
- 77.3 Inquiry into Matters relating to the Safety of Blood Products in New Zealand: Dr Sue Morey, Hon Stan Rodger; December 1992.

RELATIONSHIP BETWEEN THE ACCOUNTABILITY MONITORING CARRIED OUT BY PERFORMANCE MANAGEMENT BRANCH AND OPERATIONAL MONITORING CARRIED OUT BY THE NCSP

78. Operational monitoring by the NCSP is described by Judith Glackin in her evidence in chief at paras.319 to 346.
79. The relationships between formal accountability through the Funding Agreement, its monitoring, and the operational monitoring managed through the National Cervical Screening Programme can be shown diagrammatically as below:

1990 - 1998



80. The Performance Management Branch was responsible for RHA monitoring (monitoring the formal performance indicators set out in the Funding Agreement) and for following up any areas of non-compliance (with the service obligations) referred to it. This was a responsibility for monitoring at an agency/governance level and fed into an evaluation of overall agency performance. Operational or programme level monitoring and evaluation, which generally feeds back into policy and programme design, was a function of the policy branches.

81. The National Co-ordinator had responsibility for oversight and co-ordination of the Programme, including monitoring of the performance of

the Programme through her close interactions with the local programme co-ordinators and providers and through the information provided through the programme. The AHB/RHA role was to monitor the performance of providers, including providers of services relating to the NCSP, against their contracts with those providers.

82. As the diagram above shows, there is a link between the formal accountability arm of the Ministry (RHA monitoring) and the operational monitoring function. There has always been a mechanism for any part of the Ministry to provide information on concerns about RHA performance or sector performance more generally to the Performance Management Branch, and to request a more formal follow up and escalation through the accountability process. This process is used regularly and there are at least 2 instances where the National Cervical Screening Programme referred issues of concern to Performance Management Branch to resolve through the formal accountability process including:

82.1 backlog of enrolments on the Auckland register, and

82.2 issues around electronic data entry of histology results on the Registers.

See paragraphs 308- 311 and 329 - 334 of the evidence in chief of Judith Glackin for further details.

CURRENT HFA FOLLOW UP OF ISSUES ARISING FROM THE GISBORNE INVESTIGATION

83. The Inquiry will be aware that the HFA is currently following up issues arising from the Gisborne inquiry.
84. The Performance Management Branch is responsible for ensuring that the HFA is making appropriate progress in following up issues arising from the Gisborne inquiry. In order to do this, the Branch co-ordinates information and advice from the Ministry's policy branches and the HFA and then follows up issues with the HFA and actively manages the issues if progress is not adequate. If the Branch (or policy branches) was not

satisfied with progress, issues would be escalated in line with the escalation path noted above. The Ministry's Chief Medical Advisor and Chief Advisor Services are both involved in these processes.

85. At this stage, the Ministry is satisfied with the HFA's progress in managing this issue and has reported accordingly in the quarter two performance report to the Minister as well as its monthly financial/risk report to the Minister. Extracts from the most recent quarter report and financial/risk report to the Minister are exhibited as **DGL/MOH/0012** and **0013** respectively.

THE FUTURE MANAGEMENT OF THE PROGRAMME

86. As all are aware, the current health sector changes require the transfer of some of the HFA's functions to the Ministry. A joint Change Steering Committee is overseeing the work. A process has been approved in which all aspects of the NCSP, including funding, will be brought together within the National Screening Team of the Public Health Operating Group within the HFA. This work to bring all aspects of the project together is already under way within the HFA. This change will enable quality standards, monitoring and quality improvement processes to be more readily implemented and amended as required.
87. It is planned to continue this arrangement for national management, coordination and funding of the Programme when the relevant HFA functions are transferred to the Ministry of Health. The organisational design for the new Ministry of Health therefore proposes that the Programme will be managed centrally within the new Public Health Directorate of the Ministry. The integration of the HFA and the Ministry functions does not mean any present functions will be lost or moved out. The Ministry and HFA acknowledge the WHO organisational requirements for a successful cervical screening programme and aim to meet these, within the new sector arrangements.

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SWORN by the abovenamed deponent at Wellington this day of June 2000
before me:

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A Solicitor of the High Court of New Zealand

Exhibits Produced by David George Lambie

VOLUME 1

Ref. No.	Exhibit
1	Review of RHA Contracting 1994/95

VOLUME 2

Ref. No.	Exhibit
2	Review of RHA Contracting 1994/95: Appendix

VOLUME 3

Ref. No.	Exhibit
3	Policy Guidelines to RHAs, November 1992
4	Policy Guidelines for RHAs 1994/95
5	Policy Guidelines for RHAs 1995/96
6	Policy Guidelines for RHAs 1996/97

VOLUME 4

Ref. No.	Exhibit
7	Feedback received during development of the Funding Agreement
8	Compendium of References to Cervical Screening over the Relevant Period

VOLUME 5

Ref. No.	Exhibit
9	Review of Health Funding Authority Quality Specification and Monitoring of Selected Services
10	Extract from Health Outcome Targets 1998
11	Extract from Population Based Health Outcomes, June 1996
12	Extract from Quarter Two 1999/00 Report on HFA Performance
13	Extract from Health Report 9 May 2000