POLICY IMPLEMENTATION

AND

ADMINISTRATIVE ARCHITECTURE

Using the Purchaser Provider Model to Implement ACT Health and Community Care Delivery Policy

By

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Abstract

In their seminal work on policy implementation, Pressman and Wildavsky (1973:143) have argued that 'there is no point in having good ideas if they cannot be carried out.' The use of a New Public Management (NPM) service delivery approach in the Australian Capital Territory (ACT) health area, referred to as the Purchaser Provider Model (PPM), was seen as one of those good ideas. The then-ACT Government hoped that the use of this model as part of its public policy reform agenda would assist it in successfully achieving its goal of restraining the growth of ACT public health care costs. The PPM was in operation between 1996 and 2002, when it was discontinued, suggesting a policy implementation failure.

In this thesis, the PPM is used as a case study as a basis for supporting the argument that the administrative architecture through which public policy is implemented plays a crucial part in the success or otherwise of the implementation of that policy, especially in the area of public service delivery. The administrative architecture is defined as, the administrative components that have been designed to assist the implementation of public policy.

To undertake the analysis the PPM is expressed in terms of the following three extremely important components of the administrative architecture:

- the configuration of role and role relationships;
- resource allocation arrangements; and
- the performance management framework.

Pattern matching logic in conjunction with the literature is used to show how crucial was the part played by the above components and hence the administrative architecture in the implementation of public policy.

While the thesis provides compelling evidence (based on the case study and the academic literature) to support its claim, the crucial part played by the administrative architecture in the implementation of public policy, especially in the area of service delivery, has hitherto received little attention in the implementation literature.

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I appreciate the support provided by the many people who provided me with background information and other useful documents. Furthermore, I am particularly grateful for the numerous people who were willing to be interviewed. I was especially impressed during the interview process by the many people who devoted much of their time and energies to support the various non-government services which the ACT government “purchased” from them, at bargain basement prices. It was easy to understand why they did not see the Purchaser Provider Model as placing them on a level playing field with their government provider ”competitors”.

Finally, I would like to thank my wife Enid, for her patience and understanding during the course of this Thesis.

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Abbreviations and Acronyms

ACHS	Australian Council on Health Care Standards
ACT	Australian Capital Territory
ACTCC	ACT Community Care
ACTCOSS	ACT Council of Social Services
ACTHCCS	ACT Health and Community Care Service
ACTMHS	ACT Mental health service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
AN-DRGs	Australian National Diagnosis Related Groups
Calvary	Calvary Public Hospital
Calvary Private	Calvary Private Hospital
CATT	Crisis Assessment and Treatment Team
CEO	Chief Executive Officer
CGC	Commonwealth Grants Commission
CSDA	Commonwealth State/Territory Disability Agreement
DHCC	Department of Health and Community Care
DRG	Diagnosis Related Groups
HACC	Home and Community Care
NATSEM	National Centre for Social and Economic Modelling at the University of Canberra
NHCDC	National Hospitals Costs Data Collection
NHS	National Health System (in the UK)
NPM	New Public Management
PPM	Purchaser Provider Model
SAHS	Southern Area Health Service
SCFPA	Standing Committee on Finance and Public Administration
TCH	The Canberra Hospital
The Board	The ACT Health and Community Care Service Board
WVH	Woden Valley Hospital

Chapter 1

Introduction

Even the very best policy is of little worth if it cannot be implemented successfully. However, the implementation of public policy is always a difficult task, with implementation failure, in part or whole, a well known and common result. As a field of research, the implementation of public policy began in earnest following the 1973 seminal work of Pressman and Wildavsky in their book *Implementation,* and as Winter has observed:

> implementation has already been analysed from many different perspectives, representing different research strategies, evaluation standards, concepts, focal subject areas, and methodologies (Winter 2006:151).

In fact, a feature of contemporary implementation research is the diversity of the approaches taken as part of a move away from earlier attempts to develop a general theory of public policy implementation (Hughes 1994:152; Winter 2003a:207). The later approaches have been designed to give some insight into a particular dimension of the reality of implementation (Parsons 1995:489).

Despite the additional research that has been undertaken, putting public policy into action still provides many challenges, with implementation failures leaving many unanswered questions (O'Toole 2000:265). As part of this academic research some attention has been given, for example, to issues of: policy design by Linder & Peters (1984); May (2003), Winter (2003), and Bobrow (2006); and implementation structures by Hjern & Porter (1981); Hogwood & Gunn (1984); Hanf & O'Toole (1992); and Peters (1999b). However, consideration of the administrative architecture through which public policy is implemented (this concept is defined later in this Chapter and is further elaborated on in Chapter 2) is an area of implementation research that has hither to received little attention in the implementation literature.

In this thesis it is argued that such administrative architecture plays a crucial part in the success or failure of implementation. To support this proposition the thesis presents the results of case study research related to a New Public

Management (NPM)-type of policy reform in the health area in the Australian Capital Territory (ACT), namely the introduction of administrative arrangements and procedures referred to as a Purchaser Provider Model (PPM).

NPM Reforms and the PPM

NPM reforms began in the 1980s, and took place during a period when governments in most advanced industrial countries were trying to reduce the size of both their fiscal deficits and their public sectors (Schwartz 1994:48). The main thrust of NPM approaches to service delivery has been, that market based approaches to government activity should replace hierarchical ones (Pollitt & Bouckaert 2000:79-80). Furthermore, NPM reforms were aimed at developing more entrepreneurial and competitive forms of market-based government service delivery that were both efficient in using scarce resources, and effective in meeting the desires of clients and citizens for better quality services (Lynn 1996:21; Aucoin 1995:9; Koch 2000:11; Rose 1994:94).

While NPM was based on economic values and objectives, it was a loose, fuzzy and multi-faceted concept incorporating many strands of administrative reform (Christensen & Laegreid 2002:19; Liegl 2001:73), and the approach taken to, and the extent of the impact of, NPM reforms has varied considerably between nations. The concept had considerable influence in a number of OECD countries, and especially in Australia and New Zealand (Commonwealth Department of Finance 1995; Halligan 2001:16-17; Hughes 2003:266-269; Pollitt & Bouckaert 2003:12-13).

In the health sectors such reforms were expected to provide considerable benefits especially in relation to hospital service delivery (Ashton 1999:141; Bloom 2000:22; Lewis et al. 1996:2). However, the reforms were later seen to be difficult to implement and not providing the expected outcomes. Also, they faced opposition from within the health sector (Ashton 1999:143 &145; Lewis et al. 1996:4; Ovretveit 1995:10; Smith 1999:179-180). Consequently such reforms generally had a limited lifespan in many countries and constituencies (Eagar et al. 2001:46).

A set of NPM reforms, referred to as the Purchaser Provider Model (PPM), was introduced into the ACT in July 1996 as part of what was seen as an international trend in public management reform (Weeks & Anderson 1995:70). In areas of ACT government service delivery such as health, major aims of the reforms were to deliver high quality services to the community at less cost and to enhance the role of consumers (ACT Chief Minister's Department 1996:6; ACT Legislative Assembly 1996:1037). However, the PPM was discontinued in the ACT health area in 2002 following an announcement by the ACT Chief Minister on 19 June 2002. In summary, the reforms provided by the PPM were seen as resulting in a lack of clear roles, confused accountability, structural and legislative impediments to the link between health policy and health service delivery, and a lack of efficiency through competition (Stanhope 2002:2-3). In effect, as elsewhere, the PPM did not live up to the expectations of NPM in the health area; failing to assist in the implementation of public policy objectives.

NPM Reforms and Policy Implementation

Public management reform has been defined as:

> *deliberate changes to the structures and processes of public sector organisations with the objective of getting them (in some sense) to run better* (Pollitt & Bouckaert 2004:8 & 16 original emphasis).

From a public policy implementation perspective, NPM reforms such as the PPM, among other things, changed the administrative architecture through which public policy was implemented (Christensen & Laegreid 2002:24). In this thesis the administrative architecture is defined as:

> The administrative components that have been designed to assist the implementation of public policy.

This administrative architecture can be viewed from a number of perspectives (see Forbes & Lynn 2005:569), but in this thesis, the focus is on the following components:

- the configuration of role and role relationships;
- resource allocation arrangements; and
- the performance management framework.

These components were chosen because they were significant aspects of the administrative architecture through which public policy is implemented:

- the appropriate role of government actors and other actors and their relationships was an important part of the policy implementation process (May 2003:229);
- resource allocation is a core issue associated with the provision of public services (Fisher 1998:1; May 2003:223);
- improvements in performance management have been an important aspect of public sector reform (Bovaird & Loffler 2003:17).

Also, in regard to the provision of public health services, NPM reforms:

- challenged the traditional role of public organisations;
- changed the way in which resources were allocated; and
- gave rise to new forms of performance management (Scott [C] 2001:18).

Thesis Proposition and Research Questions

The thesis proposition is that the administrative architecture through which public policy is implemented plays a crucial part in the implementation of that policy, is somewhat broad. While there was no evidence from this thesis to suggest that such a broad proposition was incorrect, the research in this thesis was limited to examining the use of the PPM as an administrative architecture in the health area in ACT. Therefore, the main research question that was addressed by way of a case study in this thesis was:

- How appropriate was the PPM as an administrative architecture for the implementation of NPM-type policy in the ACT health area?

However, to make the thesis research more manageable it focussed on the three significant components on the administrative architecture referred to above, so the actual research questions that were addressed in this thesis were:

- How appropriate was the configuration of role and role relationships that was developed as part of the PPM approach?
- How appropriate were the resource allocation arrangements that were developed as part of the PPM approach?
- How appropriate was the performance management framework that was developed as part of the PPM approach?

Justification for the Research

This research is important, because the implementation of public policies is a significant aspect of policy analysis (Salamon 2002:7). Also, the

implementation process is clearly an essential part of putting public policy into action to produce results for citizens, so, an understanding of important aspects of the implementation process is seen as crucial to the understanding of service delivery arrangements (DeLeon 1999:328; Parsons 1995:465; Peters 1999a:123).

The study focuses on an important area of public policy implementation that has been in effect ignored, and contributes not only to an understanding of issues associated with implementation failure, but also to those that can contribute to its likely success. As O'Toole (2000:265) observes 'the practical world is now just as much in need of valid knowledge about policy implementation as it ever has been.' Furthermore, service delivery is an important public service function and central to the role of the state (Hughes 2003:155; O'Faircheallaigh et al. 1999:162), with the provision of public health services being one of the major and most visible public services provided by government, so this thesis examines an important area of service delivery from an implementation perspective.

The generalisability of the results of this thesis had the potential to be limited because it was based on a single case study. While further research would help to confirm or reject the wider proposition put forward in this thesis, there was ample evidence in the literature to support a conclusion that the domain of the results can be extended to the implementation of public service delivery.

Methodology

The methodology used to address the research questions and the thesis proposition is at Chapter 4 and involves the use of:

- qualitative research methods;
- a case study approach;
- semi-structured interviews, documents, and the academic literature as the major data sources;
- purposive sampling as the main form non-probability sampling; and
- multiple sources of data to provide triangulation of results.

Structure of the Thesis

In summary, the remaining Chapters provide the following structure for the thesis:

Chapter 2	Provides: an overview of issues in the academic literature relating to the implementation of public policy, a definition of and elaborates on the concept of administrative architecture, and reviews significant issues in the literature related to important components of the administrative architecture;
Chapter 3	Provides an overview of: health services in the ACT, health funding in the ACT, 1996 financial reforms and the PPM, and health reforms in the ACT;
Chapter 4	Outlines and justifies the methodology used in this thesis;
Chapter 5-7	Presents and reviews the data related to the research questions;
Chapter 8	Addresses the research questions and the thesis proposition, by drawing on data from interviews and documents in Chapters 5, 6, and 7 and related comments in the Literature Review (Chapter 2)**;**
Chapter 9	Sets out the thesis conclusions that include: arguments that support the generalisability of the findings; generic types of situations that result in the development of an administrative architecture that does not assist the implementation of public policy; and a major lesson that can be drawn from the thesis.

Chapter 2

Literature Review

In this thesis it is argued that the administrative architecture through which public policy is implemented plays a crucial part in the implementation of that policy. This Chapter provides a background to, and the basis for, this proposition through an overview of issues in the academic literature relating to the implementation of public policy. The Chapter first considers the concept of public policy, and then reviews literature related to common approaches to policy implementation and other relevant implementation matters.

In summary, the Chapter shows that:

- in recent times the concept of public policy has been expanded to take into account the involvement of both public and private sector actors;
- there is a move away from attempts to develop a general theory of policy implementation, towards research into specific aspects of implementation; and
- there is no agreement about what should be the key research concepts or subjects to be addressed.

The Chapter also:

- considers issues in the literature related to: policy design, implementation structures, and both the concept “administrative architecture” and its relevance to the implementation of public policy;
- identifies three important components of the administrative architecture; and
- discusses significant issues in the literature relating to these components, especially those that underpin the analysis in Chapter 8.

Public Policy

In the academic literature there appears to be considerable agreement about what policy is (Anderson 1975:3; Hill & Hupe 2002:5; Hogwood & Gunn 1984:22; Howlett & Ramesh 1995:4; Jenkins 1978:15). Most definitions are similar to that of Anderson who defines a policy as:

> A purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern (Anderson 1975:3).

In regard to “public policy” Peters and Pierre (2006:2) note that ‘there has been a tendency in the analysis of policy to consider primarily, or solely, the

role of the public sector and official actors in the process, and to ignore the role of private sector actors.' For example, Anderson (1975:3) defines a public policy as one 'developed by governmental bodies or officials.' However, Hogwood and Gunn (1984:23) express the view that because public policy involve, a key, but not exclusive, role for public agencies, it may not have been significantly developed by government but it must have been 'partly developed *within* the framework of government.' More recently, Althaus et al. (2007:8) see public policy as ultimately about achieving government objectives and as 'a course of action by government designed to attain certain results.' Such a view of public policy is the one adopted in this thesis.

Public Policy Implementation

In the literature, the term implementation is often used as a short hand for public policy implementation (Pressman & Wildavsky 1973; deLeon 1999a; Hill & Hupe 2002). Further, Pressman and Wildavsky state that:

> Implementation to us means just what Webster and Roget say it does: to carry out, accomplish, fulfil, produce, complete. But what is being implemented? A policy naturally (Pressman & Wildavsky 1973:xiii).

Hupe and Hill (2006:18) see that it is through the implementation process that the intentions of public policy are realised. Implementation is thus considered to be a vital step in putting public policy into action to produce results for citizens, and an understanding of the important aspects of the implementation process is seen as crucial to the understanding of service delivery arrangements (deLeon 1999a:328; Parsons 1995:465; Peters 1999a:123).

IMPLEMENTATION ANALYSIS

The major approaches to the analysis of public policy implementation have either had a "top-down" or a "bottom-up" perspective, or have tried to synthesise these approaches (Hill & Hupe 2002).

The Top-Down Perspective

The top-down perspective, which is the basis of much early implementation research, focuses on implementation from the perspective of policy makers.

Implementation is seen as primarily a matter of assembling action to support the intentions of political leaders (Finlayson 2001:161; Hill & Hupe 2002:173). As an analytical approach, the top down perspective starts with the decisions and objectives of the government, examines the extent to which administrators carry out or fail to carry out these decisions, and seeks to find the reasons underlying the extent and success of implementation. It is largely concerned with how the implementing officials can be made to do the job more effectively and needs clear goal statements to work with (Ham & Hill 1993:110; Howlett & Ramesh 1995:153 & 156-157).

According to Mazmanian and Sabatier, the essential features of a top-down approach involve addressing the following questions:

1) To what extent were the actions of implementing officials and target groups consistent with (the objectives and procedures outlined in) that policy decision?
2) To what extent were the objectives obtained over time, i.e. to what extent were the impacts consistent with the objectives?
3) What were the principal factors affecting policy outputs and impacts, both those relevant to the official policy as well as other politically significant ones?
4) How was the policy reformulated over time on the basis of experience? (Mazmanian & Sabatier 1989:289).

A major issue associated with the top-down approach is a concern about the "implementation gap", or "implementation deficit", between what is expected and what is achieved (Hill & Hupe 2002:11). One of the consequences of this concern was the development of generalised policy advice in the 1970s and 1980s. Matland noted that the common policy advice was:

> Make policy goals clear and consistent (Van Meter and Van Horn 1975; Mazmanian and Sabatier 1983); minimise the number of actors (Pressman and Wildavsky 1973); limit the extent of change necessary (Van Meter and Van Horn 1975; Mazmanian and Sabatier 1983); and place implementation responsibility in an agency sympathetic with the policy's goals (Van Meter and Van Horn 1975; Sabatier 1986), (Matland 1995:147).

The Bottom-Up Perspective

The bottom-up perspective starts with those actors nearest to the problems to be solved by policies. This perspective is seen as having two advantages. First, it is considered to be more realistic to look at policy from the view of the target population and the service deliverer. Second it is felt that unless local level implementers are given the freedom to adapt a program at the local

level, it is likely to fail (deLeon 1999a:316; Howlett & Ramesh 1995:157; Matland 1995:148-150; Winter 2003a:206). In addition, the approach is seen by Williams as concentrating attention on the service deliverer and the client, and as addressing a core implementation issue:

> by highlighting the *barriers* faced by the service delivery organisation and the *resources* it has or can develop for serving clients (Williams 1982:6-7, original emphasis).

Multiple Perspectives

While a dispute between the advocates of the top-down and bottom-up perspectives raged for a number of years it is now generally accepted that rather than one approach being superior to the other, both approaches provide different insights into implementation problems (Hill & Hupe 2002:197; O'Toole 2000:268; Winter 2003b:215). Hill and Hupe (2002:173) note that O'Toole (2001:10) asserts that top-down proponents see implementation as primarily a matter of 'assembling action in support of the intentions and orders of political leaders' with a focus on compliance and monitoring, whereas bottom-up proponents look at implementation as 'mobilising the energies of disparate stakeholders to make sensible choices in congealing problem solving around a complex, context-specific, and dynamic policy issue.' However, in the view of Winter each approach 'tended to ignore the portion of the implementation reality explained by the other' (Winter 2003b:215). Consequently, the limitations of the top-down and bottom-up approaches resulted in attempts being made to synthesise these approaches.

Because of the different perspectives, and their respective limitations attempts to synthesise them are numerous (Hill & Hupe 2002). Among those to develop a synthesised approach are Elmore (1982 & 1985), Sabatier (1986), Goggin et al. (1990), Matland (1985), and Winter (1990 & 2003b). These approaches are outlined in Appendix A.

Despite sufficient evidence being accumulated to partially validate both the top-down and bottom-up arguments, and despite numerous attempts to synthesise these approaches, none of them are seen as providing a complete picture of the reality of implementation (O'Toole 2000:268; Parsons

1995:489; Winter 2003b:215). Therefore, it is not surprising that Winter (2003a:207) considers that there is little common ground about what should be the key concepts to be addressed in public policy implementation research, or the subjects that researchers should study. A further consequence of this lack of common ground is that approaches to the study of implementation have become more diverse, with a move away from attempts to develop a general theory of public policy implementation (Hughes 1994:152; Parsons 1995:489). As Parsons (1995:489) notes implementation problems can be analysed in a variety of different ways, with each approach giving some insight into a particular dimension of the reality of implementation. One issue that appears to have been given inadequate attention is the administrative architecture through which public policy is implemented. Instead there has been a focus on matters such as the "stages approach" to policy implementation, policy design, and implementation structures.

The Stages Approach

Because of the complexities associated with the development and implementation of public policy, implementation is often viewed as part of a process with a number of successive phases or stages (Anderson 1975; Brewer & DeLeon 1983; Hill & Hupe 2002; Stokey & Zeckhauser 1978). For example, these stages have been referred to as:

- agenda setting;
- policy formation – of policy formulation and decision making;
- implementation; and
- evaluation (Anderson 1975:19; Hill & Hupe 2002:167-168).

In the view of Peters and Pierre:

> The overall rationale of the stages approach is that what actors do at one stage of the policy process is to a large extent framed by what other actors have done earlier in the process (Peters & Pierre 2006:6).

However, the stages approach is subject to criticism. Nakamura (1987) considers it is unrealistic and a "textbook approach"; Hogwood and Gunn (1984:217) argue that policy formulation and policy implementation are interdependent activities; and Calista (1994:131) notes that policies are

continuously designed and redesigned because desirable policies are rarely self-evident. Also, Sabatier (1999:7) considers that the stages approach:

- is not a causal theory;
- is often inaccurate in describing the sequence of stages;
- is legalistic;
- has a top-down bias; and
- is over-simplistic.

Despite his criticisms, Sabatier (1986:31) sees disadvantages, from an evaluation perspective, in 'obliterating the distinction between (policy) formulation and implementation.' While also accepting the limitations of the stages approach, Hill and Hupe (2002:168) similarly argue that it is undesirable to completely write off the stages model, and noted that it gives sense, direction, and legitimation to the things that actors in the policy process are expected to do. They also accept the case for the stages heuristic functioning as a general map for the analysis of the policy process (Hupe & Hill 2006:27).

deLeon (1999b:26) considers that, despite its lack of predictive capabilities, the major strength of the stages approach is that it provides a means of categorising policy actions as they vary from stage to stage. Similarly, Parsons sees it as a useful heuristic device, and argues that:

> given the sheer range of frameworks and models which are available as analytical tools, we need some way in which this complexity can be reduced to a more manageable form (Parsons 1995:80).

In terms of the stages approach, the focus in this thesis is on what is referred to as the implementation stage, and in particular the administrative architecture through which public policy is implemented, as these lie at the core of the thesis argument. For as John (1998:204) states, 'implementation is the stage in the policy process concerned with turning policy intentions into action.'

Policy Design

In the view of Bobrow and Dryzek (1987:201) 'Design is the creation of an actionable form to promote valued outcomes in a particular context.' Parsons (1995:564) notes that interest in a design approach to public policy could be traced back to Simon (1969) who considers that design is a means both of understanding reality and acting on it. Linder and Peters (1984:253) go

further and argue that ‘examining problems from a design perspective offers a more productive way of organising our thinking and analytical efforts.’ Furthermore, Bobrow (2006:76) considers that that ‘policy designs are representations of what might be turned into realities.’

In discussing the influence of policy design on policy implementation, Winter (2003a:208) and May (2003:223) both assert that, in a policy design context, policies do more than announce a course of action. They also contain:

- a set of goals;
- a mix of instruments for obtaining those goals;
- a designation of government and non-government entities charged with carrying out the goals; and
- an allocation of resources for the requisite tasks.

These policy design elements provided useful insights that influenced the development of the research methodology (at Chapter 4) and especially the framework for analysis in Table 4.1.

Implementation Structures

As an element of policy design, the concept of ”implementation structures” has a much narrower scope than the concept of “administrative architecture” used in this thesis. Concepts associated with implementation structures are narrowly focused on:

- entities such as agencies, organisations, parts of organisations and networks, and on programs; and
- the “actors” that implement them.

For, as Hjern and Porter state:

> An implementation structure is the administrative entity which programme implementers use for accomplishing objectives within programmes (Hjern & Porter 1981:211).

Early implementation researchers such as Hogwood and Gunn (1984) were concerned with identifying the preferred policy implementation structures, which they saw as ones that involved a single agency, and considered that one of the conditions of “perfect implementation” is that there:

> is a single implementing agency which need not depend on other agencies for success, or if other agencies must be involved, that the dependency relationships are minimal in number and importance (Hogwood & Gunn 1984:202).

Other researchers address the wider context in which policy is implemented. Hjern and Porter (1981:222) consider that as analytical constructs, 'implementation structures are conceptualized to identify the units of purposive action which implement programs.' In this context, Hanf and O'Toole argue that:

> The idea of the 'implementation structure' was developed to provide a conceptual perspective from which to examine purposive action in those situations where such *parts* of public and private organisations co-operate in performing the different tasks involved in the implementation of a particular programme (Hanf & O'Toole 1992:175, original emphasis).

However, Hjern and Porter warn that while implementation structures are composed of many parts of organisations they are not organisations. They see the failure to identify administrative structures as administrative entities distinct from organisations as leading to severe difficulties in administering the implementation of programs, as almost no program is fully implemented by a single organisation. In their view:

> Programs are implemented by a cluster of *parts* of public and private organisations, i.e. implementation structures. An implementation structure is comprised of *subsets* of members within organisations which view a programme as their primary (or instrumentally important) interest. For these actors, an implementation structure is as much an administrative structure through which purposive actions are taken as the organisations in which they are employed (Hjern & Porter 1981:216, original emphasis).

Furthermore, they note that:

> Within implementation structures, *sub groups of actors and organisations perform specialised roles.* There are substructures *for policy making, planning and intelligence, resource provision, intermediary and coordinating roles, service provision and evaluation* (Hjern & Porter 1981:223, original emphasis).

In line with the view of Hjern and Porter, Peters (1999b:90) sees the creation of implementation structures as involving structural relationships among organisations, and argues that the concept of implementation structures place the strategic interactions of participants into their larger institutional context. In addition, Cline (2000:569) considers that the utilisation of implementation structures allows one to focus on different actors involved in different processes at different levels.

IMPLEMENTATION ARCHITECTURE

In reviewing the literature related to the issue of implementation architecture consideration is given to the use of the term “architecture” in a management context, the “administrative architecture” concept and its definition, and important components of an administrative architecture.

Architecture in a Management Context

In management and related contexts it is not uncommon for the term architecture to be used with wider connotations than its use in common language. For example, in discussing his bureau-shaping model of bureaucracy, Dunleavy (1989) refers to the ‘Architecture of the British Central State’ as his framework for analysis. Pollitt and Bouckaert (2004:25-26) refer to the broad architecture of their model of public management reform, which consists of socioeconomic forces, the political system, elite decision making, and an administrative system. Furthermore in relation to bureaucracies, Meier and Smith argue that:

> An architect plans a blueprint around the occupants and intended function of a building, not around the most efficient source of drafting paper. Similarly, policymakers should plan policy around an understanding of the nature and functioning of bureaucracies, rather than the institutions that design them (Meier & Smith 1994:438).

The term architecture is also used in an organisational context (Brickley et al. 2006; Gerstein 1992; Nadler et al. 1992; Wade and Recardo 2001). Gerstein (1992:13) sees several advantages in addressing issues from an architectural perspective:

- the notion of architecture is a reminder that design is only part of the process;
- the term architecture is able to be applied to a wider set of characteristics than the term structure; and
- the term architecture emphasises the need for harmony among the various elements.

Administrative Architecture

There appears to be no definition of administrative architecture in the literature, so drawing on the views of Gerstein and, being mindful of the

above comments of Meier and Smith (1994), in this thesis the term "administrative architecture" is defined as:

> The administrative components that have been designed to assist in the implementation of public policy.

Public policy implementation is multidimensional and quite complex (Palumbo & Maynard-Mooney 1991:303). There appears to be no one perspective through which the administrative architecture can be viewed. Therefore, it is necessary to find some way of simplifying the approach, to have any chance of understanding important aspects of it. Sabatier asserts that this be done by examining issues through simplifying propositions (Sabatier 1999:4-5).

It is not uncommon for researchers to focus on a small number of components when considering architecture from an administrative perspective. For example, in considering the architecture of the British Central State, Dunleavy (1989) focuses on a set of agencies, kinds of budgets, and personnel. Similarly, when considering organisational architecture, Brickley et al. (2006:323) focus on what they see as three important components: the assignment of decision rights; the methods rewarding individuals; and the structure of systems to evaluate the performance of both individuals and business units.

This thesis advances the proposition that three important components of the administrative architecture through which public policy is implemented are:

- the configuration of role and role relationships;
- the resource allocation arrangements; and
- the performance management framework.

My earlier research (Collins 1997) concerning use of the PPM in the areas of health and community care, education and training, and urban services in the ACT provided an initial basis for the view that the configuration of role and role relationships, resource allocation arrangements, and the configuration of role and role relationships had an important bearing on the implementation process. Also the review of the literature suggests that these components are generic and important in the area of public service delivery. In the literature these components are seen as important because in regard to role and role

relationships, the appropriate role of government and other actors, and the pattern of inter-organisational relations are major issues that revolve around both general and specific policy considerations (Scott [C] 2001:18; May 2003:229; Peters 1999b:90; Ranson & Stewart 1994:141). Peters (1999b:90) sees the implementation of public policy as requiring a network of actors and formalised patterns of interactions. In addition, May argues that:

> The intermediaries that are charged with policy implementation and how they share responsibilities are important aspects that constitute the implementation structure for a given policy (May 2003:229).

For example, in the public health area, the role of clinical professionals and their relationship with managers is seen as an important influence on public policy implementation (Sutherland & Dawson 1998:S16-S17).

In relation to resource allocation arrangements, not only are management and policy implementation activities intimately concerned with directing flows of resources to achieve defined outcomes, but also resource allocation is a core and often contentious issue associated with the provision of public services and especially public health services (Fisher 1998:1; Draper 1999:147; Hughes 2003:60; Simon 2000:756).

Improvement in performance management, with a shift from a focus on conforming with procedures to a concern about results, has been a crucial part of public service reform and in particular NPM type reforms (Bouckaert & Halligan 2008:46-49; Bovaird & Loffler 2003:17; Flynn 2002:115; Kettl 1996:259; Hughes 2003:157). Furthermore, performance management is seen as using strategies and mechanisms to assign responsibility for strategic initiatives to specific units and individuals, and holding them accountable for results (Bryson 2003:40).

Components of the Administrative Architecture: Major Issues

Roles and Role Relationships

Palumbo and Maynard-Moody (1991:107-108) define a role as ‘a predictable set of expectations and behaviours associated with an office or position.’ They assert that some roles may permit a variety of behaviours, while other

roles may be generalised and share common traits. They refer to these latter roles as “role types”. Abercrombie et al. state that the concept of a role:

> assumes that, when people occupy social positions, their behaviour is determined mainly by what is expected of that position rather than by their own individual characteristics (Abercrombie et al. 2002:301).

Roles

Implementation and NPM literature tend to focus on different issues relating to roles. The implementation literature is usually concerned with describing the actual roles that are undertaken and associated relationships rather than appropriate roles (Hjern & Porter 1981; Lipsky 1980; O’Toole 2000). There is a focus on role types such as policy makers, street-level bureaucrats (front-line or field-level workers), and the target population for the policies being implemented. The relative importance of the roles undertaken by policy makers and street-level bureaucrats in influencing outcomes is a major issue. For example, in the bottom-up approach, the role of street-level bureaucrats is considered as important, and sometimes more important than that of policy makers because of the position of street-level bureaucrats at the interface of the state and citizens, and their opportunities to exercise discretion. Moreover, street-level bureaucrats are seen as exerting influence well beyond their formal authority, often because of their expertise (Lipsky 1980; Meyers & Vorsanger 2003:246; Winter 2003b:214). While the role of target groups (consumers) do not receive the same level of prominence they are seen as playing an important role, because they are regarded as crucial to a policy’s effectiveness (Schneider & Ingram 1997:84).

In contrast, in NPM and related literature the major role issues are related to matters such as:

- role clarification;
- a more autonomous and competitive role for providers; and
- an enhanced role for consumers.

Role Clarification

Achieving greater role clarity by separating roles with fundamentally different purposes is a major issue in NPM approaches (Osborne & Plastrik 1997:95). The major focus is on the roles of politicians, bureaucrats, service

purchasers, service providers and consumers (Clarke & Newman 1997; Lane 2000; Scott [C] 2001). Also, as in the case of this thesis, a distinction is sometimes made between the ownership and purchasing roles of government (Scott [G] 2001:21) in order to avoid the purchasing role dominating the ownership role (Gill 2001:57; Scott [G] 2001:212). However, the usefulness of this distinction has been questioned. Gill argues that:

> While these have proved useful concepts as ways of thinking of things in practice, it has proved difficult to separate the two interests. This is not surprising. They are best seen as something like a continuum where purchase is the short term manifestation, and ownership is the long term manifestation, with a large degree of overlap in the middle (Gill 2001:157).

Furthermore, Schick (1996:44) sees the solution to the problem, of the purchasing role dominating the ownership role, as 'more detailed specification of ownership issues in performance agreements.'

Autonomous and Contestable Roles for Providers

The provision of *more autonomous* roles for providers under the NPM approach is related to the concept of "let the manager manage", and is often considered central to NPM-type approaches (Clarke & Newman 1997:56; Pollitt 1993:3). Moreover, as noted by Peters and Pierre (2000:12-13), it is argued that organisations work better if their lower echelons are given more autonomy. However, the provision of such autonomy is seen as highlighting the organisational dilemma of providing both autonomy to and control over providers (Peters & Pierre 2000:16-17). Christensen et al. (2007:160) consider that 'the price of increased autonomy is subjection to a more rigid performance management system.'

In the health area – which is highly professionalised – It is asserted by Preston and Badrick that:

> Professionals require autonomy for effective professional and personal satisfaction. This need for autonomy leads to conflict between the professionals and the managers who seek to manage them (Preston & Badrick 1998:333).

Furthermore, autonomy is seen as a key feature of medical dominance (Germov 1999:236-237), and in the health literature much attention is given to the dominant position of doctors and the role they play in influencing

service provision because of the autonomy they exercise (Belcher 2005:284; Bennett & Ferlie 1996:63; Clarke & Newman 1997:63; Germov 2005:291-298; Mc Murray 1999:343; North 1995:46; Peters 1999a:279; Sutherland & Dawson 1998:S16-S23). Preston and Badrick (1998:317) claim that 'Hospitals have become organisations of specialists where functional expertise is valued and managerial expertise is not.' The view has been expressed that as the result of the introduction of NPM-type approaches in the NHS, managers:

> were increasingly eyed suspiciously as agents of the government and usurpers of professional power and dominance (Sutherland & Dawson 1998:S20).

The provision of a more *contestable* role for providers is seen as providing an opportunity for improvements in productive efficiency (Boston et al. 1996:93). In situations such as those that exist for government providers in the ACT, it is argued that cosy relationships between a sole or small number of purchasers and dominant providers can reduce competition (Hoyes & Means 1997:295; Means et al. 1994:177). However, the provision of a more competitive role for non-government not-for-profit providers of community services is seen as potentially having adverse effects on relationships, with competition for contracts having the capacity to strain or destroy mutual support networks built up over many years (Knapp et al. 1994:139).

Enhanced Role for Consumers

Consumers are supposed to have an enhanced role under NPM-type approaches (Peters & Pierre 2000:19; Scott [G] 2001:68). For example, Street (1994:373) notes that while a purchaser/provider separation (as part of such an approach) is supposed to allow consumers a greater role in the health care system, there is nothing in the system that can allow this. Especially in the area of hospital related services, the health care consumer is at a great disadvantage because of the specialized knowledge of the clinician (Hall & Viney 2000:42; Turner 1995:133). Furthermore, Ferlie et al. (1996:192) claimed that evidence from the U.K. did not indicate that the NPM quasi market approach gave the consumer greater direct influence or control in the health area: the dominance of the medical profession stayed largely intact.

At an operational level, the role of consumers is expected to be enhanced in service delivery areas by the separation of the purchasing and providing roles and by the purchaser assuming a proxy consumer role, to ensure that provider and customer/client/user interests are separately represented (Lewis et al. 1996:2). Of these arrangements, the use of role separation to avoid the minister and the purchaser being captured, respectively by the department and providers, is one of the more controversial aspects of NPM. It is based on the public choice theory proposition that government intervention on the basis of market failure does not take self-interest and opportunistic behaviour into account, and that this is leading to politicians and bureaucrats being captured by interest groups, acting opportunistically, and putting their interests before those of clients (Lowery 1999:34; Schwartz 1994:55; Scott et al. 1997:360).

The idea that public sector actors act opportunistically is widely questioned in the literature (Boston et al. 1996 29-32; Clarke & Newman 1997:84; Howlett & Ramesh 1995:21; Udehn 1996:194-195). Further, the NPM approach contrasts with both mainstream implementation and health approaches. In the implementation literature (Lipsky 1980:72) stresses the advocacy role of street-level bureaucrats/providers. Also, the advocacy role is seen as especially important for providers in the health sector (Bateman 2000:37-43).

Role Relationships

Role relationships are regarded as important in both mainstream implementation and NPM literature. However, the approaches taken are somewhat different. In the implementation literature there is a major focus on relationships between:

- policy makers and street-level bureaucrats;
- street-level bureaucrats and target groups; and
- organisations and actors in organisations.

A major issue regarding the relationship between policy makers and street-level bureaucrats is the extent to which policy makers can direct and limit the discretionary role of street-level bureaucrats (Meyers & Vorsanger 2003:249). Especially where there is considerable complexity, this task is seen as difficult and sometimes impossible (Calista 1994:134; Meyers & Vorsanger

2003:246-247). On the other hand, it is argued that through the discretion they can often exercise, street-level bureaucrats have the capacity to undertake a role that either advantages or disadvantages target groups or clients (Lipsky 1980**;** Meyers & Vorsanger 2003:249).

In regard to relations between organisations and organisational actors, O'Toole (2003) considers inter-organisational relations are to be crucial for policy implementation and argue that:

> generating successful policy implementation means inducing cooperation, and perhaps even coordination, among interdependent actors in the face of impediments (O'Toole 2003:237).

Furthermore, O'Toole (2003:238) is of the view that implementation is affected by the type(s) of interdependence in an inter-organisational pattern. As will be shown below, the views of O'Toole on cooperation are in sharp contrast to the inter-organisational competitiveness encouraged by NPM.

In contrast, in the NPM literature, the major role relationships considered important are those between:

- politicians and bureaucrats;
- service purchaser and service providers; and
- consumers, and purchasers and providers.

Under NPM approaches the first two sets of relationships are seen as based on the proposition, from agency theory, that they are relationships between principals and agents (Aucoin 1995:35; Scott [G] 2001:28).

Politician and Bureaucrat Roles

The separation of the roles of politicians and bureaucrats within a government agency is seen as allowing politicians to focus on the determination of political goals and the control of public agency management performance, and chief executives of agencies to focus on the management of their agency's performance. Schick (1996:42) sees the separation of the role of the Minister and the departmental CEO as reducing the fuzziness between the roles, and avoiding situations in which responsibility falls between the cracks. Furthermore, the separation is seen as providing

efficiency gains by ensuring that ministers are not drawn into the day-to-day operations of agencies (Loffler 1998:10; Schick 1996:42).

The extent to which political and management separation provides efficiency gains by allowing government to concentrate on overall policy making and avoid being drawn into the day-to-day operations of Departments is questionable (Lane 2000:144 & 151; Laffin 1997:48; Loffler 1998:10; Schick 1996:42). Lane (2000:144) notes that it is difficult to achieve a clear-cut distinction between politics and management. He expresses the view that when things go well, government stays at arm's length from the executive agency. On the other hand, when things go wrong, politicians find it very difficult to stay far away from things. In the view of Loffler (1998:10), once political goals in contracts are fixed, the only way in which politicians can influence outputs is by way of process management. Also in 2001 Scott [G] (2001:109-110) reports that the experience in New Zealand is that some ministers are not up to the role of dealing in an arm's length, and sometimes directive way, with strong-willed and well-informed chief executives who have their own agendas and priorities.

Purchaser and Provider Roles

The separation of purchaser and provider roles is seen as resulting in those that undertake the purchaser role moving away from a passive funder role to a more active role that focuses on outcomes to be achieved and outputs to be produced, whereas, those who undertake the provider role become responsible for the delivery of agreed outputs, rather than focusing on inputs and processes (Domberger 1998:47; Eagar et al. 2001:45; Hughes 1998:70). The separation is also designed to weaken the influence of providers over service specification, and hence strengthen the possibility that service design reflects user rather than provider needs (Knapp et al. 1994:133).

Boston et al. (1996:88) consider that concerns about provider (and bureaucratic) capture are exaggerated and the view that institutional separation is the best way to reduce capture is open to doubt. Therefore, they (1996:94) assert that 'organisational designers need to avoid becoming fixated with the issue of provider capture, or with seeing functional separation

as an automatic remedy.' Furthermore, Scott [G] (2001:90) refers to experience in New Zealand which shows that role separation arrangements are not as successful in areas where the government retains a strong interest in the provider organisation. Also, Schick (1996:75) expresses the opinion that where the government owns an authority and obtains non-contestable outputs there appears to be little benefit in keeping purchasers and providers at arm's length. The above issues are very significant in the context of this thesis.

Relationship of Consumers with Purchasers and Providers

The use of role separation between purchasers and providers, together with the provision of a proxy consumer role for purchasers, is seen (as mentioned earlier) as weakening the influence of providers over service specifications, and hence strengthening the possibility that they reflect user rather than provider needs (Knapp et al. 1994:133). The idea of purchasers operating as proxy consumers is also related to the assumption that in large constituencies local purchasers can make better decisions on behalf of clients than central planners (Fisher 1998:189; Pollitt & Bouckaert 2000:79). Therefore where purchasers become proxy consumers it is their responsibility to build consumer preferences into service delivery arrangements and contract for them (Yeatman 1996:288). However, the idea that purchasers (indirect consumers) have the interests of consumers at heart and know what consumer's interests are has been questioned, especially in relation to the provision of community care (Hoyes & Means 1997:295).

Resource Allocation

As noted earlier, resource allocation is seen as a core – and often contentious – issue associated with directing flows of resources to achieve defined outputs and outcomes associated with the provision of public services such as health-related services (Fisher 1998:1; Draper 1999:147; Hughes 2003:60; Simon 2000:756). However, Fisher argues that:

> The question confronting people interested in public services is not 'what is the best way of allocating and delivering public services?' but 'what in any particular time and place, is the most broadly acceptable way of allocating and delivering goods and services?' (Fisher 1998:251).

In addressing resource allocation issues, there is a marked difference between the descriptive focus of mainstream implementation literature and the somewhat prescriptive focus in the literature relating to NPM, where there is a concern with economic goals and the means of achieving them. In mainstream implementation literature there is a focus on: the adequacy of resources, which is seen as having a significant impact on implementation outcomes (Hogwood & Gunn 1984:199-200); and the involvement of street-level bureaucrats in the rationing of services, with the often adverse impact on target groups (Lipsky 1980; Meyers & Versanger 2003; Winter 2006:153). For example, while street-level bureaucrats are seen as having expert knowledge they are able to use to benefit their clients, there is a concern that, in situations where there are pressures on resources, street-level bureaucrats discriminate and introduce their own biases into the rationing process (Meyers & Versanger 2003:249).

In NPM and other literature, there are several resource allocation issues that are relevant to this thesis, namely: rationing, value for money and cost containment, output focus, contracts, contestable procurement arrangements, and consumer needs.

Rationing

In the private sector, price is used to equate supply with demand and ration scarce resources, whereas price is rarely used in the public sector (Flynn 2002:14). In areas of the public sector where there is an absence of market prices, rationing is used to manage demand for scarce resources (Vidler & Clarke 2005:26-34). Under NPM approaches rationing is seen by Clarke and Newman (1997:150) as becoming more visible and explicit. However, in the health sector, Harrison and Wistow (1992:124) claim that rationing decisions under NPM approaches are largely implicit, with rationing decisions being 'delegated away from government.'

While rationing is important as an instrument in both allocating public health services and reducing the impact of health care costs (Turner 1995:165 & 192), Duckett (2000:158) asserts that there are political difficulties in

introducing formalised rationing strategies in the public health area, especially when this approach appears contrary to the values held by the general public. In areas such as health, rationing involves considerable clinical autonomy. It usually occurs through the use of professional judgment by doctors and others and on the basis of clinical convention where an overriding concern for the individual patient/client tends to prevail (Eagar: 2000:3; Vidler & Clarke 2005:34). As Harrison argues:

> Clinical autonomy is a politically unobtrusive method for the inevitable rationing of health care. The whole functionality of this form of rationing is, of course, undermined if the process becomes explicit (Harrison 1999:63).

Literature relating to rationing is further discussed when consideration is given to the needs of consumers.

Value-for-Money and Cost Containment

Value-for-money and cost containment are significant objectives of NPM approaches. In particular, value-for-money is an appealing concept. However, it is often difficult to operationalise. In a report on *Australian Government Procurement* by the Joint Committee of Public Accounts and Audit (1999:41), it is stated that 'most agencies defined value for money but could not provide evidence of any systematic approach to assessing performance in determining value for money.' Furthermore it is noted that a lack of information regarding value for money is also demonstrated by performance audits conducted by the Australian National Audit Office. Loffler (1998:12) claims that when goods are provided free it is difficult to determine value-for-money. Also, Johnston (1998:23) argues that while the value-for-money approach may be suitable where governments purchase economic services, for human services, where funding is often input-based, methods for determining a purchase price for a particular service do not have this rational basis.

Cost containment often provides an alternative goal to value-for-money especially in the health sector. In 2000 one of the major contributors to an inquiry into Australian public health funding argued that Australian hospitals are geared to constraining costs rather than achieving value for money (SCARC 2000:9). Despite this, Hancock and Mackey (1999:87) observed that cost containment in the area of health and especially acute care has

been a difficult problem internationally. As Kingdon (1995:137) asserts health is a highly emotive issue and that 'the pressure to opt for heroic expenditures to save lives seems nearly irresistible.'

Output Focus

The move to output funding as part of the NPM approach is conceptually a change from cost-based to price-based purchasing of government services, giving CEOs the responsibility for choosing the mix of inputs necessary to produce a given output at least cost (Caiden 1998:270). A focus on the volume of outputs and output prices/costs rather than the level of inputs consumed is seen as providing a sounder basis for budgeting by identifying what is being produced and what it cost (Scott [G] 2001:172). Furthermore, it is argued that the more precision that is used in the description of outputs, the greater is the control by government over the allocation of resources (Scott 1996:33).

In regard to the provision of health services, the specification of outputs and prices to be paid is substantially addressed by the use of a casemix approach in key areas of hospital activity (Degeling 1993; Eagar et al. 2001:77; Fetter 1999; Stanton 2002:208-209; Swerissen & Duckett. 2002:24). The Casemix approach (which is outlined in some detail in Chapter 3 and Appendix B) is seen as advantaging purchasers and giving them a better awareness of what they are buying from hospitals (Duckett 2000:159; Stanton 2002:209). However, during the period of the PPM it was not an approach that received strong support from the medical profession, where it was seen as detrimental to patient care by focusing on single episodes of care and throughput, rather than on the total needs of the patient (Nelson 1994:S4-S6; Picone & Hathaway 1998:103-104; Stanton 2002:208-209). Unlike areas where casemix is used, in the community health sector it is claimed that it is difficult to specify requirements in terms of outputs and prices (Hoyes & Means 1997:298). Therefore, the use of outputs as part of resource allocation arrangements is not without serious limitations for the provision of health services.

Contracts

The use of contracts and contracting out are major features of NPM approaches to service procurement (Lane 2000:10). Contracts are seen as creating a distribution of risk between purchasers and providers, with the appropriate form of contract depending not only on who can most appropriately bear the risks involved but also upon the relative power and bargaining strength of the purchaser and the provider (Lane 2000:153; Walsh 1995:113-114).

While contracts are seen as an essential medium for markets and quasi-markets to operate, it is argued that they give rise to questions about supply and prices/costs (Bennett & Ferlie 1996:51; Lane 2000:154; Mulholand & McAlister 1997:23). To include the outputs to be purchased and the prices to be paid for them in contracts, Ovretveit (1995:133) considers it is necessary for purchasers to have access to reliable information about quality, provider activity and capacity, and costs/prices in relation to planned contractual levels. However, obtaining this information is not necessarily easy. Also, while quality is an important part of the purchase interest of government (Scott [G] 2001:17), stating the quality of services to be provided is often a difficult issue for purchasers (Boston et al. 1996:277; Clarke & Newman 1997:120; Ovretveit 1995:152). Also, as Scott asserts (1996:33), outputs have to be capable of being costed, and not involve a large element of overlap with other outputs. However, in the absence of contestability of supply, (as is largely the case in this thesis) the pricing of outputs specified in contracts is inevitably an argumentative process (Scott [G] 2001:182), as price setting procedures and structures are typically idiosyncratic often involving heuristic assessments (Fisher 1998:187-188; Tool 1995:73).

Contestable Procurement Arrangements

Under NPM approaches, contestability is usually achieved by using competition and/or benchmarking (Weeks & Anderson 1995:38-39). However, there are reservations about the use of competition in areas such as public health related services, which are seen as unlikely to have the features of a competitive market, because there is intensive government intervention (Ellwood 1996:12 & 164).

Peters (1999a:279) claims that while encouraging competition in the medical-care industry is appealing as a solution to many problems, there are important differences between it and other industries that reduce the utility of competition as a remedy. Standard competition mechanisms are less applicable because:

- professionals are dominant in determining the amount and type of care consumed by patients;
- very little information on the price or quality of medical care is available to the consumer; and
- beyond hearsay, little information is available to patients about the quality of services provided by individual physicians or hospitals.

In addition, problems can arise where:

- there is a small number of buyers and sellers;
- the price mechanism is poorly developed;
- cosy relations exist between monopoly or near-monopoly purchasers and dominant providers; and
- cost, quantity, and quality information available to purchasers is deficient (Blanchard et al. 1998:501; Means et al. 1994:177; Howden-Chapman & Ashton 1994:75).

As an alternative to competition, benchmarking is seen as providing a basis for making the public sector more competitively attuned (O'Faircheallaigh et al. 1999:28), and as an important technique in establishing whether non-government providers can deliver some function or activity more effectively than government providers (Codd 1996:183). However, Walsh (1995:93) is of the view that benchmarking techniques which are common in the private sector are difficult to operate in the public sector. In the hospital sector in Australia, the use of Diagnosis Related Groups (DRGs) to standardise for differences in the casemix of hospitals provides a benchmarking system for funding hospitals (Duckett 1998 108-110: Stanton 2002: 209). However, Scott notes that experience in the health sector in New Zealand shows that benchmarking pricing studies:

> must be embedded in a contracting framework and a wider relationship agreement that establishes prior agreement about what method will be used to collect data and what the emerging data will be used for. Otherwise, the arguments can be endless about when a particular figure for a price is sufficiently robust to be entered into a contract (Scott [G] 2001:182-183).

Needs of the Consumer

Greater emphasis on the needs of consumers is a feature of NPM-type approaches. From an operational perspective this (as is discussed in Chapter 6) involves determining consumer needs as well as meeting consumer needs. While these activities are often considered to be discrete, Ovretveit (1995:108) expresses the view that it is difficult, and, many argue, inappropriate to detach assessing needs from meeting needs, and sees these activities as part of a continuum.

Irrespective of whether determining or assessing consumer needs is a continuum, in the view of Yeatman (1996:288) one of the problems is how to develop the wants of the individual into the institutional design. Loffler (1998:11) notes that where public goods are concerned the citizen and the consumer are not identical. Therefore, where public goods are involved it is necessary to weigh up the needs of specific consumers against the needs of other consumers and the public as a whole (Peters & Pierre 2000:15). Furthermore, O'Faircheallaigh et al. (1999:69) claim that 'there are limits to the extent to which services can be customised to client needs.' The purchaser of services is not only a proxy consumer but also a proxy citizen, and in such situations it is asserted that where the wants of consumers are at odds with the wants of citizens, the latter's wants usually take priority (Alford 2002:344).

In relation to health services, Eagar (2000:3) claims that there is no really systematic way to define health care standards and establish who is entitled to what level of health care. Also, Ovretveit (1995:108) argues that there will never be a full picture, as information concerning needs will always be partial and disputable, and as Kerley and Starr (2000:190) assert, consultation is time consuming and a luxury not always available to the policy maker. Furthermore, it is necessary to balance identified need against available resources. While in market based systems a price mechanism is used (Ellwood 1996:38), for services such as public health where funding is generally provided by a third party, and the product is free at the point of service, there are no price signals to influence the level of demand (Ross et al. 1999:23), rationing has to be used. However, from the perspective of

consumers of public services, rationing is seen far from ideal in meeting the needs of consumers. As Flynn (2002:122) argues, rationing limits their freedom as someone else is always involved in the rationing decision, and the choices that can be made.

Performance Management

In the view of Bouckaert and Halligan (2008:105) performance management may be defined as taking responsibility, and being responsible for a system. Also, Armstrong (2000:33) states that 'performance management is largely about managing expectations.' Performance management and performance measurement became a dominant theme in the public sector in most OECD countries in the late 1990s (Talbot 1999:15). Improvement in performance management, with a shift from a focus on conforming with procedures to a concern about results, was a crucial part of public service reform that occurred at that time (Bouckaert & Halligan 2008:46-49; Bovaird & Loffler 2003:17; Flynn 2002:115; Kettl 1996:259; Hughes 2003:157). In terms of this thesis important aspects of performance management that are relevant are: objective (goal) clarity, accountability, and performance measurement.

Objective Clarity

The lack of objective clarity is often seen as hindering performance and the implementation of public policy (May 2003:224), with flexibility, ambiguity, conflict and opportunistic behaviour seen as aspects of the political environment that militate against the development of clear political and public sector objectives (Aucoin 1995:248; Christensen et al. 2007:86-87; Matland 1995; Spearritt 1997:33). However, it is asserted that under NPM approaches to service delivery commercial objectives are brought to the fore and political objectives are consigned to the background (Christensen et al. 2007:87). As discussed in Chapter 7 in the PPM objective-clarity is sought through a performance management framework that involves the:

- separation of ownership and purchasing objectives;
- use of contracts to specify performance; and
- specification of performance in terms of outputs.

Separation of Ownership and Purchasing Objectives

The separation of ownership and purchasing objectives is an approach to clarifying performance objective that came largely from New Zealand (Scott [G] 2001; Schick 1996; Weeks & Anderson 1995). In outlining the reason for the separation, the view is expressed that, on the one hand, ownership objectives should relate to future as well as current capacity, and decisions about the appropriate level of investment in physical and human capital (Schick 1996:44; Scott [G] 2001 205-206). In supporting this reason, Scott argues that:

> The notion of a government owning an organisation captures the powers it has to direct its activities and invest and dis-invest in its assets (Scott [G] 2001:206).

On the other hand, the purchasing objectives are seen as being based on the assumption that there is an agreed set of overall policy goals with a focus on outputs to guide purchasing, with the performance management process beginning once outputs are appropriated in the Budget (Boston & Pallot 1997:385; Scott et al. 1997:362). However, the division between ownership and purchasing objectives is seen as being somewhat artificial especially where there is a dominant government provider (Lane 2000:219). Also, Ahmed (2001:2) argues that, where the interests of the owner relate to managing the assets and resource mix to deliver high quality outputs at least cost, they converge with the purchaser's interests.

The Use of Contracts to Specify Performance

Under NPM approaches, performance management and control is often seen as a series of contractual arrangements with management by contract involving a move away from the use of hierarchical authority, to control at arm's length (Bennett & Ferlie 1996:51-53; Boston & Pallot 1997:384; Lane 2000:152 & 179; Walsh 1995:136). Also, as a means of performance management, contracting is often seen as making responsibilities explicit, and as superior to coordination in getting the job done (Lane 2000:152 & 154; Parsons 1995:331; Hancock 1999:59; Walsh 1995:112).

In NPM approaches traditional contracts are used. While such contracts have the advantages referred to above, there are also constraints:

- framing transactions is difficult and contracts are never complete (Callon 1998:255; Domberger 1998:61; Walsh 1995:130);
- Lane (2000:153) asserts that 'the actual outcome arrived at will reflect the bargaining strength of the parties involved';
- NPM type contracts are often not enforceable in a legal sense (Lane 2000:194); and
- contracting parties often do not observe or contradict what is in the contract, in what they do (Walsh et al. 1997:34).

Furthermore Walsh et al. (1997:33) consider that traditional contracts are relatively impersonal, as for example:

- the relationship between the parties are limited to contract matters; and
- terms and conditions are written, shown in detail, and contain the substantive issues.

In addition, it is argued that contracts are more to do with relationships than with what is exchanged (Walsh et al 1997:34) and that the limitations of using traditional contracts are very noticeable in areas where human services are involved (Domberger 1998:165). Moreover, the use of traditional contracts as part of the performance management framework in the health sector is seen as having the potential to give rise to problems that relate to issues such as autonomy and discretion, because clinical professionals often have goals that differ from those of managers (Alexander 2000:170-171; Boston et al. 1996:9; Davies 2000:73; Muetzelfeldt 1999:154; Preston & Badrick 1998:316-333; Sutherland & Dawson 1998:S16-S20; Turner 1995:156; Wood 1999:5). Sutherland and Dawson (1998:S16-S17) point out that clinical professionals regarded themselves as undertaking the role of guardians of clinical and professional standards, with a lack of interest in financial and other management objectives often seen as a virtue. In these circumstances where there is a need for a high degree of trust and cooperation, and contracts need to be both socially as well as technical appropriate, it is considered that relational contracts are likely to be more useful (Walsh et al.1997:35).

Performance Specification as Outputs

NPM approaches to performance specification focus on outputs (Hughes 1994:70). Such a focus is seen as occurring because public sector

requirements are notoriously difficult to specify and outcomes are difficult to measure and are open to debate and political contention (Domberger 1998:162; Kettl 1997:450-451; Scott [G] 2001:193; Spearritt 1997:33). Scott [G] (2001:192-193) accepts that outcomes are the ultimate purpose of government intention and that the relationship between outputs and outcomes in many policies is not clear. However he asserts that outcomes on their own are not well suited to provide a basis for performance management and considers that a more concrete specification than outcomes is generally needed for the guidance of departments and that outputs serve this purpose. Besides, the focus on outputs is designed to ensure that chief executives are not responsible for factors outside their control (Kettl 1997:450-451), and is seen as freeing managers from a control over inputs and making them responsible for choosing the mix of inputs necessary to produce a given output at least cost (Caiden 1998:270; Scott 1996:33).

Scott [G] (2001:172 & 178) asserts that using outputs clarifies what is being produced and what it costs, but warns that poor output specification engendered poor performance. Besides deBruijn (2007:4) states that 'achieving output targets does not tell us anything about the professionalism and/or quality of the performance,' and argues that an effort to reach output targets may even harm professionalism and quality. The literature indicated that such comments are particularly relevant to health which is seen as an area where there is often a considerable lag between an intervention or treatment and an outcome with some uncertainty about the relationship between treatment and health outcome for many conditions (Mc Murray 1999:68-69; Palmer & Short 2000:104)

Accountability

In the implementation literature, the top-down approach is concerned with the extent to which administrators carry out government decisions, and the related issue of how implementing officials can be made to do the job more effectively (Ham &Hill 1993:110; Howlett & Ramesh 1995:153 & 156-157). On the other hand, in the bottom-up approach the issue of accountability

largely arises in the context of the discretion street-level bureaucrats exercise (May 2003:230; Meyers & Vorsanger 2003:249).

In NPM literature, accountability arrangements typically take a managerial accountability form and are seen as being designed to ensure that those with delegated authority are carrying out agreed tasks in accordance with performance criteria, with providers held accountable to purchasers through an agreed contract, and a process for the verification of the work done (Ferlie et al. 1996:198 & 212; Hughes 2003:249). A focus on outputs is seen as providing a reliable basis for enforcing managerial accountability because the supply of outputs can be attributed to performance (Schick 1996:74; Scott 1996:33). However, Pierre and Peters (2000:196) warn that one of the main problems facing NPM type approaches is defining a robust system of accountability and addressing the tremendous complexities in identifying who is responsible in a market-designed system of public service delivery.

In addition to ensuring that those with delegated authority are carrying out agreed tasks, managerial accountability is also seen as shifting power from producers to consumers, and viewing accountability more in terms of consumer rights than citizen rights, with public services more directly accountable to consumers (Ferlie et al. 1996:211; Clarke & Newman 1997:66). Consumers are expected to be able to exercise accountability through channels other than traditional bureaucratic mechanisms by using consumer choice, direct client satisfaction or dissatisfaction, and stakeholderism (Caiden 1998:270-271; Hughes 2003:248-249; Pierre & Peters 2000:67).

While the NPM approach includes a managerial accountability focus on consumers, Hughes (2003:247) observes that even under a managerial accountability approach, political accountability still exists. Furthermore, in the view of Mulgan (2004:9-16) governments still retain ultimate accountability for all serviced provision, and ministers and public servants can not escape accountability for service quality. Consequently all service delivery agencies can not avoid the political accountability process. In addition while in the health area, NPM-type approaches provide the basis for

greater managerial accountability of clinicians (Eager et al. 2001:78), health is an area where professional accountability exists. Romzek (2000:336) argues that professional accountability is appropriate where a task is very specialised and the managerial strategy is focused on outcomes, because it allows the application of expertise and the exercise of discretion. However Mulgan (2000:36) argues that professional accountability involving accountability to peers provides a basis for conflict with managerial accountability: an issue very relevant to this thesis.

Performance Measurement

In the implementation literature there is a concern that performance measurement is difficult, with a tendency to only report what is measurable (Hogwood & Gunn 1984:10 & 220-222; Lipsky 1980:48-51 & 166-169). However, performance measurement is seen as a central feature of NPM type public management reform that began in the 1990's (Flynn 2002:223; Heinrich 2003; Pollitt & Bouckaert 2000:86). NPM approaches to performance measurement focus on outputs (Hughes 1994:69). As noted earlier, such a focus is seen as occurring because public sector requirements are notoriously difficult to specify and outcomes are difficult to measure and are open to debate and political contention (Domberger 1998:162; Kettl 1997:450-451; Scott [G] 2001:293; Spearritt 1997:33). Kettl (1997:451) sees output measurement as the building block of performance measurement systems as 'there can be no assessment of outcomes without first gauging outputs.' Also, deBruijn (2007:8) sees performance measurement as having a number of benefits, with a major one being that of transparency.

Despite the widespread use of performance measurement as part of the NPM performance management approach, and its perceived advantages, Talbot (2005:502-505) notes that there are many criticisms of performance measurement including the cost of collecting information, incompleteness of information, difficulties in measuring quality, and the complexity of performance measurement systems. Moreover, deBruijn (2007:20) claims that where information is highly aggregated and remote from the primary

process where it is generated, it may veil an organisation's performance, an issue very relevant to this thesis.

One of the major issues that is of importance in this thesis is the focus and number of performance measures that should be used. It is often seen as important that performance measures focus on a small number of critical objectives (Hilmer 1991:i-iii; Kaplan & Norton 2001:360; Merchant & Van der Stede 2003:639). In addition, Hughes (2003:161) considers that performance measures needed to be meaningful but parsimonious. It is seen as necessary to avoid performance management systems becoming bloated and losing their simplicity in the process, a phenomenon that deBruijn (2007:39) calls the "law of mushrooming".

Despite the support for a small number of performance indicators, Kaplan and Norton (2001:360) warned that problems could occur when either too few performance measures are used, or when too many performance drivers are used and the critical few are not identified. Also, Bourne and Bourne (2000:44) consider that it is important to consider why a performance measure is being used, with Parsons (1995:548) claiming that 'measures of performance in themselves mean nothing.' Also, as noted earlier deBruijn (2007:4) warns that 'achieving output targets does not tell us anything about the professionalism and/or quality of the performance; an effort to reach output targets may even harm professionalism and quality.'

In the health sector, Schacter (1993:3) asserts that each performance measure should reflect an aspect of what people expected from the sector, without placing too much emphasis on single performance measures. However, even as late as 2005, Smith (2005:219) expressed the view that health systems are still in the early days of performance measurement and there remains an enormous agenda to improve their effectiveness. One of the major difficulties in the health sector is measuring and controlling quality (Ovretveit.1995:160-161). To address this problem, both Ovretveit (1995:160-161) and Walsh et al. (1997:49) recommend that providers use a quality assurance scheme that they can demonstrate to purchasers. As

Brunnson (1999:118) argues, it is often easier to use standards than to exercise control through directives and orders. Besides, as Flynn (2002:115) comments, professionals use standards rather than instructions to determine what and how services are delivered.

SUMMARY

The review of the literature provides both an academic underpinning for the thesis proposition, and findings that support the analysis in Chapter 8 and the conclusions in Chapter 9.

This thesis is part of what is seen in the literature as a general move away from attempts to develop a general theory of policy implementation, towards research into specific aspects of implementation. A review of the literature shows that the administrative architecture through which public policy is implemented is an issue that appears to have been given inadequate attention and thus is an area where there is a gap in the research. This thesis aims to make a contribution towards filling that gap in the research. It contributes a definition of “administrative architecture“ which is developed from and underpinned by relevant ideas in the literature and for the purposes of this thesis is taken to be:

> The administrative components that have been designed to assist in the implementation of public policy.

It is also shown that there is support in the literature for the assertion in this thesis that the configuration of role and relationships, resource allocation arrangements, and the performance management framework are important components of the administrative architecture. A review of literature relevant to these components provides data to support the thesis proposition, and the analysis in Chapter 8, by showing for the configuration of role and role relationships:

- the limitations of role separation arrangements;
- the difficulties in providing an enhanced role for consumers by restraining the role of providers and giving inadequate consideration to their advocacy role;

- the important role of providers and the difficulties in using arm's length relationships to control providers; and
- the downside of giving providers greater autonomy.

The literature also demonstrates, in regard to resource allocation arrangements:

- the need for rationing where public services are supplied free;
- the difficulties that arise when there is a lack of robust cost/price data;
- the limitations of using competition in the health sector; and
- that in both assessing and meeting consumer needs it is necessary to balance the needs of the specific consumers against the needs of other consumers and the public at large.

Further, in relation to the performance framework, the literature shows:

- the difficulties in achieving objective clarity ;
- the need for sound and robust data for the specification of performance as outputs;
- the need to address both managerial and political accountability issues where public services are involved; and
- the difficulties in undertaking useful performance measurement.

The next Chapter provides the background to the case and in particular details of ACT health arrangements just prior to and during the PPM.

Chapter 3

Background to the Case

ACT Health Arrangements

This thesis uses a single case study to examine the administrative architecture through which public policy is implemented, utilising data related to the implementation of NPM-type public policy reforms in the health sector in the ACT. This Chapter provides background to the case study with an overview of:

- health services in the ACT;
- health funding in the ACT, including Commonwealth and ACT Funding;
- 1996 ACT financial reforms and the PPM; and
- health reforms in the ACT.

More specifically this Chapter provides:

- a summary of the ACT's responsibilities, administrative arrangements and service provision arrangements in regard to public health
  - showing that the ACT has both state and local government health responsibilities, and is a significant supplier of hospital services to a large area surrounding the ACT;
  - outlining service provision arrangements especially for hospital, community care and mental health services, which were the major public health services provided by the ACT Government;
- an overview of Commonwealth, and ACT funding arrangements with a focus on those that relate to hospital, community care and mental health services;
- an outline of the main pressures for financial reform, the early investigations that occurred into financial reforms and the PPM in the early 1990s
  - noting that there was bipartisan political support for the principles underpinning the reforms rather than the way it was used and that the term "purchaser provider model" (PPM) applies to a package of reforms that includes more than the purchaser-provider split; and
- a synopsis of the 1996 health funding reforms in the ACT with a focus on the pressures for reform, and the interest in and use of purchaser provider split type reforms.

HEALTH SERVICES IN THE ACT

Responsibilities

Prior to 1988 the ACT was administered by the Commonwealth Government. It became a self-governing Australian territory in 1988 under the *Australian Capital Territory (Self Government) Act 1988*. Under that legislation the ACT Government has both state and local government responsibilities in regard to the provision of health services. Its major responsibilities cover a range of health activities including health promotion, health regulation, the provision of hospital services, community care activities, and mental health programs (Productivity Commission 1999:232). In 2001-02, the last year of the PPM, expenditure by DHCC on health and community care services was approximately:

- 65.4% on hospital services;
- 25.3% on community care;
- 6.1% on mental health; and
- 3.2% on health protection services, which were largely regulatory in nature (ACT Government 2002b:117-123).

The ACT Government provides public health services not only to ACT residents but also (under cost recovery arrangements with the NSW Government) to residents of the surrounding South Eastern Region of NSW which during the PPM period (1996-2002) had a population of 181,700 (ACT Government 1999d:12). Thus, while the ACT population was around 300,000, at that time, the total number of people who potentially had access to some health and hospital services provided by the ACT was about 500,000 (Lee Koo 1998:57).

ACT Administrative Arrangements

In the period prior to and during the use of the PPM, (1992-2002) the administrative responsibility for the health services which were purchased on behalf of the ACT Government rested with the Minister of Health and Community Care (the Health Minister) and the Department of Health and Community Care (DHCC). In the period prior to the implementation of the PPM, there were four main areas of administrative responsibility: public

hospital services, community care, public health, and corporate and strategic development (ACT Government 1996d:12).

With the implementation of the PPM in 1996 the responsibility for public health, policy and planning, financial management, and purchasing activities remained within DHCC. However:

- The government owned public hospital (the Woden Valley Hospital (WVH)) was renamed The Canberra Hospital (TCH) and it no longer reported to DHCC;
- Mental health services previously provided by the government owned public hospital were put in a separate organisation responsible to the hospital and known as the ACT Mental Health Service (ACTMHS); and
- The community care "provider services" of DHCC became the responsibility of ACT Community Care (ACTCC).

Both TCH and ACTCC came under the umbrella of a new statutory authority called the ACT Health and Community Care Service (ACTHCCS). They had separate budgets and separate purchase agreements with DHCC (ACT Legislative Assembly 1996a:1-2). They also had separate CEOs. The ACTHCCS was established under the *ACT Health and Community Service Act 1996* with wide powers and a board whose main responsibility was to manage the operations of TCH and ACTCC (ACT Government 1997d:6-7).

The Board of ACTHCCS consisted of seven members: the CEOs of the Canberra Hospital and ACT Community Care (as *ex-officio* members), one member nominated by the University of Sydney (because TCH was a teaching hospital associated with the University of Sydney), and up to four members appointed by the Health Minister (ACT Government 1997d:9). While TCH and ACTCC were established in July 1996 when the PPM came into operation, the members of the ACTHCCS Board (the Board) were not appointed until December 1996 for a term starting on January 1997. The Board did not meet until February 1997, so it had no involvement with some of the early administrative arrangements associated with TCH and ACTCC (ACT Government 1997d:6). These arrangements are discussed further below.

Service Provision Arrangements

To outline the service provision arrangements of the ACT Government an overview is provided of service provision arrangements relating to hospital, community care, and mental health services, prior to and during the PPM period.

Hospital Services

In the ACT, prior to and during the PPM period, hospital services were provided by a mixture of general public hospitals (TCH and Calvary), general private hospitals, and six day-only private procedures centres that were often referred to as hospitals (ACT Government 1998e:12).

When the PPM was introduced there were only two general private hospitals. They were Calvary Private Hospital (which was co-located with Calvary public hospital) and John James Memorial Hospital, which was a small stand-alone private hospital. However, in 1998 an additional general private hospital known as National Capital Private Hospital was established and co-located next to TCH. As the result of this hospital coming on stream in 1998-99 the number of beds in ACT hospitals with overnight accommodation was: TCH 524, Calvary 162, John James Private 177, Calvary Private 80, and National Capital Private 110 (ACT Government 1998e:12; ACT Government 1999d:13).

Public Hospital-Based Care

Both prior to and during the period of the PPM, public hospital-based care was predominantly provided by a government-owned hospital and a non-government-owned hospital. In the period prior to the PPM, the government owned public hospital (WVH) was under the administrative control of DHCC. At the hospital level, it was administered by a 6-member committee comprising a general manager and senior hospital staff (ACT Government 1995a:10 and private communication). Following the implementation of the PPM, the newly named government owned public hospital (TCH) was placed under the administrative control of the ACTHCCS, but with its own CEO and hospital services that were organised around a structure that focused on

medical services, surgical services, women's and children's health, and mental health services.

The non-government provider – Calvary Public Hospital (Calvary) – came under the overall management responsibility of The Little Company of Mary (a religious order) both before and after the implementation of the PPM. Its staff, other than the CEO and the executive, were members of the ACT public service. Also, until July 2001, Calvary had a management board, which was replaced with a national board covering all the hospitals run by the Little Company of Mary. However, there was a local advisory group associated with the hospital, which consisted of a community council of eight with an independent chairman.

Functions of WVH/TCH and Calvary

Both prior to and during the PPM, the ACT undertook an approach which involved a degree of hospital role specialisation that has been referred to as role delineation (DHHCC 2001:20). Under this approach WVH (and later TCH) and Calvary had defined but somewhat overlapping roles. WVH (and later TCH) acted as the major trauma and tertiary care facility offering acute and long-term specialised care and a large range of other services. It was also a teaching hospital of the Canberra Clinical School of the University of Sydney, and the primary referral hospital for the adjacent Southern Area Health Service (SAHS) area of NSW. Calvary provided general hospital services to the residents of the ACT region with a focus on the north side of Canberra, a number of outpatient services, and was a referral centre to WVH/TCH (ACT Government 1995b:91 &123).

Provision of Hospital Services for Areas Adjacent to the ACT

Referrals from the adjacent SAHS region to the ACT assisted ACT hospitals, and particularly TCH, in achieving a level of critical mass for the provision of some services. During the PPM period the rate of reimbursement for these services was a matter of friction between the ACT and NSW Governments, with reimbursement determined as an arbitrated rate rather than a negotiated rate (private communications). An officer of the SAHS noted in February

2002 that the SAHS received a set amount of funding each year from the NSW Department of Health to cover referrals to the SAHS region and from it to other areas such as the ACT. The view was expressed that often patients were sent to Canberra for elective procedures because of personal relationships between doctors, rather than for purely health care reasons.

Community Care Services

There was no commonly accepted definition of "community care." In this thesis it was taken to include activities covered by ACT programs such as: home and community care, drug and alcohol services, community health services, health support for people with disabilities, indigenous health, and aged health care. In the period prior to the implementation of the PPM in 1996, ACT-funded community care services were provided by staff of the Community Division of DHCC or by non-government providers. More information of the activities of the Community Division and non-government providers during that period is in Appendix B.

Following the introduction of the PPM approach in 1996 the provider functions of the Community Division of DHCC were taken over by ACT Community Care which undertook the following programs:

- Women's Health;
- Alcohol & Drugs;
- Child, Family and Youth Health;
- Community Health Care;
- Dental Health; and
- Disability (ACT Government 1997d:45).

Non-government providers supplied a range of services targeting: the aged and disabled, those with drug and alcohol problems, Aboriginal health, women, and children and youth (ACT Government 1996b:192).

Mental Health Services

Prior to the implementation of the PPM, mental health services were undertaken either as part of the role of WVH, or by Calvary and a small number of non-government providers. WVH provided:

- Community services, which consisted of outpatient community-based care, forensic services, and child and adolescent services;

- Psychiatric rehabilitation services; and
- Psychiatric inpatient services, which consisted of a 32-bed ward at WVH and 60 hostel beds at two other locations (ACT Government 1996d:27).

With the introduction of the PPM, policy and planning functions associated with mental health were undertaken by DHCC. As noted earlier, the other mental health activities of WVH were transferred to a new organisation, the ACT Mental Health Service (ACTMHS), which was set up as an autonomous government mental health provider under an executive director who reported to the CEO of TCH. ACTMHS was given a major role in providing inpatient, rehabilitation, outpatient, community-based care, and the provision of forensic services.

At the same time as the PPM was introduced, ACTMHS moved to a new structure designed to be focused on a strong integrated community-based service with four regional health centres, and hospital and inpatient facilities providing backup for acutely ill or severely disabled patients. Community-based services were provided by multidisciplinary teams that provided assessment and treatment for people with mental health needs, including the services of a 24-hour crisis assessment and treatment team (CATT) (DHCC 1997b:18; ACT Government 1997d:125).

Both prior to and during the PPM, Calvary provided a range of public inpatient, assessment, hospital consultation and outpatient services for people with a mental illness. Its inpatient services consisted of a 20-bed ward providing initially sub-acute but later also acute services for the mentally ill. During the period of the PPM, the mental health services provided by Calvary expanded (Calvary Hospital 1998:10; Calvary Hospital 1999:10-11). As part of this expansion, in February 1998, Calvary opened an additional 20-bed private psychiatric assessment and treatment facility providing inpatient and outpatient services. It was the only private facility of its type in the ACT. However, an attempt in 1996 to have the 20 public psychiatric beds at Calvary gazetted so they could be available for involuntary patients was turned down, as Calvary considered that it did not have an environment suitable for such a facility (ACT Government 1996e: 8-9; private communication).

In regard to other non-government providers, in the period prior to the implementation of the PPM, providers of mental health services were not separately identified as such. However, from the details of Community Grants in the 1995-96 Annual Report of DHCC it was possible to identify nine non-government organisations that were later funded as providers of mental health services to DHCC (ACT Government 1996d:174-177). These providers and the roles for which they were funded are shown in Appendix B.

HEALTH FUNDING IN THE ACT

In outlining health funding in the ACT, Commonwealth, and ACT funding are separately considered.

Commonwealth Funding

Hospital Services

While the States and Territories were primarily responsible for the delivery of public hospital care, during the PPM period (1996-2002) the Commonwealth contributed directly about 50% of recurrent government expenditure on hospitals. The Commonwealth was also engaged in a number of other activities to support the effective funding and management of hospitals (Commonwealth Department of Health and Aged Care 2001:128). The relationship between the Commonwealth and the ACT governments was set out in formal 5-year agreements. (An outline of these agreements is in Appendix B.) During interviews, a senior executive with ACT Treasury argued that the open-ended nature of access to public hospital services provided in agreements with the Commonwealth constrained the capacity of the ACT to limit demand: limiting supply became the main option for limiting demand.

Community Care Services

Commonwealth funding for community care activities in the ACT was largely provided to the ACT Government under joint Commonwealth/ACT Agreements. When the PPM began in 1996 the Commonwealth was providing funding for a diverse range of activities and programs. The two largest sources of Commonwealth funding came from the Home and

Community Care (HACC) program and the Commonwealth/ACT Disability Agreement. The HACC program was a cost-shared program designed to support frail older people, younger people with disabilities, and their carers. The program targeted those people who without HACC services would probably go into a nursing home or hostel (HACC Program Management Manual, January 2000:9; and personal communication). Under the Commonwealth State/Territories Disability Agreement (CSDA), States and Territories were responsible for accommodation and support services, while the Commonwealth was responsible for employment and advocacy services for people with disabilities (ACT Chief Minister's Department 2001).

In 1997-98, the smaller programs were incorporated into the Public Health Outcome Funding Agreement between the Commonwealth and States/Territories, which was initially for two years. The second agreement went beyond the period of the PPM and covered the period 1999-00 to 2003-04. In the agreements, the Commonwealth undertook to provide funding to assist States/Territories achieve agreed outcomes for a range of public health initiatives (Public Health Outcome Funding Agreement between the Commonwealth of Australia and the ACT 1999/2000-2003/2004). Both, this agreement and the two referred to in the last paragraph, related to national program guidelines, which were jointly developed and agreed to by the Commonwealth and State/Territory governments and set out in broad program parameters. States and Territories were free to develop their own plans, but these were expected to reflect national strategic directions and priorities.

Mental Health

During the PPM period the Commonwealth provided funding to support National mental health policy, which was endorsed by all health ministers, and was an agreed broad strategy for the reform of the mental health sector across Australia (Australian Health Care Agreement between the Commonwealth of Australia and the Australian Capital Territory 1998:23). Under the strategy, the delivery of specialist mental health services remained the responsibility of the States and Territories governments, and it became the responsibility of the Commonwealth to work with the States (Palmer & Short

2000:288). Commonwealth funding for mental health services was integrated into the five year 1993-98 Medicare Agreement, and the five year 1998-2003 Australian Health Care Agreement between the Commonwealth and the ACT.

ACT Funding

In the following overview of ACT funding, issues related to ACT Budget funding arrangements, and DHCC funding arrangements are covered.

ACT Budget Funding Arrangements

In the period prior to the implementation of the PPM in 1996, funds were appropriated to DHCC in the ACT Budget within a program structure. Programs were further divided in to sub-programs. For example, the program "Woden Valley Hospital" was divided into nine sub-programs and outlays were allocated to each sub-program. With the introduction of the PPM, the ACT Budget remained the primary vehicle for allocation resources, and DHCC was still regarded as an appropriation unit, but funding was appropriated in terms of broad output classes and sub-classes. In all but the first year of the PPM a distinction was made between the funding for outputs related to "payments for services purchased" by contract from providers, and the funding for other outputs (See Table 3.1).

DHCC Funding Arrangements

In 1995, the year prior to the introduction of the PPM, DHCC consisted of divisions relating to corporate and strategic development, population health, hospital and associated regional services, and community health. With the introduction of the PPM, the role of DHCC was limited to policy and planning, purchasing, and population health, and within DHCC policy and purchasing roles were separated (ACT Government 1996b:111). The hospital, community care, and mental health service requirements of the ACT Government were purchased by DHCC. These services are separately discussed further below. In the final financial year of the PPM (2001-02), the responsibilities of DHCC were expanded to include housing, and the Department was then referred to as the Department of Health Housing and Community Care (DHHCC).

Table 3.1

OUTPUTS FOR HEATH SERVICES: BY YEAR AND OUTPUT CLASS 1996-97 to 2001-2002

Year	Output Class			
	1	**2**	**3**	**4**
1996-97	Policy Advice and Ministerial Support	Purchase of Health and Disability Services (a)	Health Protection Services	
1997-98	Policy Advice	Purchase of Health, Aged and Disability Services	Population Health	Payments for Services Purchased(b)
1998-99 &1999-2000	Policy Planning and Health Outcomes	Purchase of Health, Aged and Disability Services	Community and Health Services Complaints	Payments for Services Purchased(b)
2000-01	Policy, Planning and Purchasing of Health Services	Community and Health Services Complaints	Payments for Services Purchased(b)	
2001-02	Policy, Planning and Purchasing of Health, Housing and Community Services	Community and Health Services Complaints	Payments for Services Purchased(b)	

Notes: (a) Includes payments for services purchased.
(b) Within the output class "Payments for Services Purchased" there were output sub-classes such as hospital services, community care services, and mental health services.

Source: ACT Budget Estimates 1996-97 to 2001-2002.

Hospital Services

Hospital-based care was the most expensive component of the provision of health and community care, with public hospitals in the ACT receiving between 60% and 67% of ACT government health funding during the period 1996-2002 (ACT Government 1998c:184; ACT Government 2001c:125-128). Therefore, hospital-based care was an area that had the potential for the Government to make considerable savings with the use of the PPM. An outline of general funding arrangements for WVH/TCH and Calvary both prior to and during the PPM is shown in Appendix B, together with details of casemix funding (Diagnosis Related Groups (DRG)) arrangements used in the ACT.

Community Care Services

In 1995, the year prior to the introduction of the PPM, ACT funding for community care activities was predominantly provided through the Community Division Program. However, a small number of activities were funded under the Public Health and the Strategic Development Programs. For example, funding for the Women's Health Program came under the Strategic Development Program. The use of the PPM was associated with the replacement of a program approach to funding at an ACT budget level with output-based funding. However, while, at an ACT Budget level, the ACT Government moved to output funding, elements of program funding were retained. For example in 1997-98 when community care (then referred to as community services) became a separate output class in the ACT Budget, services provided by ACTCC were classified by a program-type approach. Also, while services provided by non-government providers were shown as a single line in the ACT Budget, they were grouped on a program basis in the annual report of DHCC (ACT Government 1997a:190-193; ACT Government 1998a:44-47). Even in 2001-02, when non-government services were incorporated with the services provided by ACTCC, a program-type approach was retained (ACT Government 2001c:127-128).

Mental Health Services

As noted earlier, prior to the introduction of the PPM in 1996, in the ACT Budget process funds were appropriated to programs and sub-programs. Under this arrangement "Mental Health" was a sub-program of the "Woden Valley Hospital" program. On the other hand, mental health services provided by Calvary were not separately identified (ACT Government 1995b:127-128). Funding for services for other non-government providers were in the form of grants and came out of one of the sub-programs of the Community Division or from other funding sources in DHCC (ACT Government 1995b:38). DHCC also had its own internal program structure. Under this structure, significant providers of mental health services were funded under the Health Grants Program or the Aged and Disability Grants Program. (ACT Government 1995b:175-176).

As with hospital services and community care services, there was not a separate Budget output class for mental health until the 1997-98 Budget. During the PPM (1996-2002) period there were purchase agreements with non-government providers of mental health services. However, the mental services provided by the ACTMHS and Calvary were incorporated into the respective purchase agreements of TCH and Calvary. Furthermore, it was not until 1997-98 that all non-government providers of mental health services were included in the mental health program in the Annual Report of DHCC. In 1996-97 several major non-government providers of mental health services continued to receive funding under other program titles.

Over the period of the PPM the range and level of non-government services funded by DHCC increased substantially until, by 2001-02, it included the following services: advocacy, counselling, information and training, living skills, outreach, peer support, recreational programs, respite care, supported accommodation and vocational rehabilitation. Moreover, in 2001-02 there were 21 non-government organisations that received funding as part of the Mental Health Program of DHCC (ACT Government 2002b:50).

1996 FINANCIAL REFORMS AND THE PPM

Prior to the introduction of self government in 1988 government services in the ACT were funded by the Commonwealth at a level that was generally considered quite generous, compared to the funding available to the Australian states. When the ACT was granted self-government it was announced that it would be gradually brought into line with the Commonwealth general purpose funding arrangements that applied to the States. However, because of the high expectations of the ACT community, the ACT had difficulty in reducing its expenditure, and increasing its revenue to account for the reduced funding provided by the Commonwealth, and at the time the PPM was introduced, the ACT was facing an already difficult budgetary outlook (ACT Government 1996a:43). It was noted in the ACT Budget for 1995-96 that in its 1995 update, the Commonwealth Grants Commission (CGC) figures showed that total actual expenditure in 1993-94 was 9.3 % above

the level required to provide an average level of services (by Australian standards) at an average level of efficiency (ACT Government 1995c:37).

Serious ACT Government investigations into possible management reforms that involved the use of the purchaser/provider split began in the 1990s under the then-Labor Government in the ACT. During that time bureaucrats in the central agencies and line departments such as DHCC showed considerable interest in developments in other Australian states, and in New Zealand where the purchaser/provider split approach was already highly developed. The Public Accounts Committee of the ACT Legislative Committee visited New Zealand to examine the reforms that had taken place there in 1994 (Standing Committee on Public Accounts 1996).

In February 1995, following the election of a Liberal Party government in the ACT, investigations into the reform process were speeded up. In June 1995, the ACT Government established a Government Reform Advisory Group to investigate and recommend improvements to the system of government in the ACT (Government Reform Advisory Group 1995:3). In its report the Group recommended the separation of funder and provider functions of government, to provide the ACT Government with ‘a new opportunity to identify more clearly the outcomes it is seeking to achieve’ (Government Reform Advisory Group 1995:12). Furthermore, the approach was in line with the ACT Government’s reform agenda which was ‘designed to increase the efficiency of the public sector and to deliver high quality services to the community at less cost’ (ACT Chief Minister’s Department 1996:6).

Collins (1997:5) reported that there was considerable bipartisan support for the thrust of most of the financial management reforms begun by the Liberal Government in 1996. Despite some reservations by the ACT Legislative Assembly Standing Committee on Public Accounts about the pace of the changes and their impact on providers, Collins noted that the legislation that underpinned the reforms had a relatively easy passage through the ACT Legislative Assembly. However, as Collins (1997:6) also reported, bipartisan political support appeared to be largely related to the general principles that

underpinned the purchaser/provider split, rather than the specific way in which it was being implemented. The opposition Labor Party appeared concerned that, in implementing the proposal, too much emphasis was being placed on the need to cut costs, especially in the areas such as health and community care. The Labor Party also appeared to have ideological concerns about anything that could be seen as a move towards the privatisation of health (Collins 1997:6).

In the health and other ACT sectors of government service provision, purchaser/provider split arrangements were introduced in 1996 as part of a financial reform package. This package has often been referred to, especially in service provision areas, as the Purchaser Provider Model (PPM) because one of its major features was the purchaser/provider split involving the separation of the roles of deciding what goods and services government will undertake (referred to as the *purchaser role*), from the role of delivering these goods and services (referred to as the *provider role*) (ACT Government 1996d; DHCC 1996a & 1996c; Johnston 1998; Lee Koo 1998; Rogan et al. 1997; Weeks & Anderson 1995).

The reform package referred to herein as the PPM included not only the purchaser/provider split but also reforms such as: other role separation splits, output budgeting, the use of contractual type arrangements to specify outputs and to control performance, the corporatisation of some service supply entities, contestable purchasing arrangements, and performance management arrangements that related accountability with responsibility (ACT Chief Minister's Department 1995a; ACT Chief Minister's Department 1996; ACT Government 1996a). In this thesis the term PPM is used to refer to this wider package of reforms in the ACT.

HEALTH REFORM IN THE ACT

Health Care Costs

As with other government services in the ACT the higher than national average costs provided pressure for health reform in the ACT. However, in

the period prior to the introduction of the PPM approach progress had been slow. Standardised per capita information published by the CGC (CGC 1996:238 & 242) showed that while there was improvement, compared with 1990-91 (the first year for which comparative figures were available), expenditure for total health services and especially hospital services for the ACT remained well above the standardised level for States and Territories in 1994-95. This is shown as percentages in Table 3.2.

In addition to the CGC information, a study by the National Health Ministers' Benchmarking Working Group (1996:29) showed that for 1993-94, on a casemix adjusted basis, the percentage by which the average cost per separation in ACT public hospitals was above the national average, was: 74.1% for medical labour costs, 22.2% for non-medical labour costs, 30.9% for other recurrent costs, and 39.1% overall. Furthermore, in the lead up to the ACT elections in 1995, the then-Liberal Party Opposition noted that the total cost of operating the then-WVH would need to be reduced by $32.9 million in order to meet the national average (Crosby 1995).

Table 3.2

COMMONWEALTH GRANTS COMMISION EXPENDITURE COMPARISIONS

1990-91 and 1994-95

	Percentage by which ACT Expenditure Exceeded the Standardised Figure for States and Territories	
Item	**1990-91**	**1994-95**
Hospital services	55%	34%
Total health	42%	24%

Source: Commonwealth Grants Commission Report on General Revenue Grant Activities: 1996 Update (1996:238 & 242).

The Purchaser/Provider Approach: ACT Health

Interest in introducing a purchaser/provider split in the health area in the ACT appears to have begun during the 1991-1994 period when Gillian Biscoe was chief executive of the then ACT Department of Health. She had health and management qualifications and experience with both health arrangements in

New Zealand and casemix funding (information provided by interviewees). The possibility of introducing purchaser/provider split and associated arrangements into the health area was also examined by the Members of the ACT Legislative Assembly Standing Committee on Public Accounts during two trips to New Zealand (May 1994 and May 1996) as part of a wider review of purchaser-provider arrangements operating there. In referring to health issues in a report on their May 1996 visit they noted that the evidence suggested that the 'purchaser provider model does not appear to have lived up to the expectations of the theory' (Standing Committee on Public Accounts 1996:12). Overall in relation to health they concluded that:

> The provision of health and disability support programs through contracted arrangements is unlikely to achieve substantial cost savings or reduce hospital waiting lists without a focussed and efficient control of service providers by the relevant government funding agency (Standing Committee on Public Accounts 1996:14).

The introduction of the PPM had also been preceded by reservations by health sector employees about what was seen as the transformation of health into a commodity and concerns about the use of the model in New Zealand and Victoria (see Appendix B).

In contrast to the concerns of the ACT Legislative Assembly Public Accounts Committee, and health sector employees, there was strong support for a "Purchase Model" in a 1995 report on *Impacts on the Health Sector of the Public Sector Management Reforms* by a New Zealand consultancy firm that was commissioned by the ACT Government (Weeks & Anderson 1995). This report noted that there were active examples of the use of a Purchase Model in healthcare in Western Australia, South Australia, New Zealand, United Kingdom, Finland, Netherlands, and Sweden, and that there was interest in the approach in other Australian States, certain other European countries and Canada. In support of the use of a Purchase Model, they suggested that:

> It is therefore, reasonable to conclude that there is a "tidal" movement, both nationally and internationally, toward the introduction of a Purchaser Model, particularly in health care, but also in certain other public services. At the present time Western and South Australia are among the leaders, (with Victoria pursuing a broadly parallel path), in these developments, here in Australia (Weeks & Anderson 1995:70).

and that:

> The design of the public sector management model for the ACT will be unique, but it will draw extensively on the best features of the reforms undertaken in New South Wales and New Zealand with a view to minimising development time and cost (Weeks & Anderson 1995:14).

In summary, Weeks and Anderson suggested that, within a purchaser/provider framework, the reforms were designed around:

- the recognition that the government has both a purchase and an ownership interest in relation to government's service delivery agencies;
- the role of the purchaser is to satisfy government objectives through the acquisition of goods and services of right quality lowest possible price and delivered on time;
- the role of government service delivery agencies (providers) is that of deliverers of services that are competitively priced and not consumers of resources; and
- an appropriation and service delivery process with a focus on outputs and outcomes (Weeks & Anderson 1995:14-16).

However, major recommendation made by Weeks and Anderson that were *not* adopted when the PPM was introduced were proposals for:

- DHCC to be replaced and its role undertaken by a Health Commission, responsible to the Minister responsible for health, which would have planning, purchasing, policy advising and regulatory roles;
- the ownership role to lie with the Minister responsible for health related issues; and
- government provider roles to be undertaken by two separate government statutory authorities (separately covering the roles of TCH and ACTCC); (Weeks & Anderson 1995:21 & 28-29).

Instead of these proposals:

- the Department was retained and undertook the purchaser role;
- the ownership role was undertaken by the Treasurer; and
- a single statutory authority covered all aspects of health delivery.

The decision to have one statutory authority instead of two occurred in part because the CEO who became responsible for DHCC in March 1996 was not comfortable with the proposal that TCH and ACTCC should be in separate statutory authorities, and so tried to develop a model that integrated everything (interview comment). In April 1996, the CEO announced that there was majority support from staff and clients, and ACT Government approval, for a single Statutory Authority. However, TCH and ACTCC were to be separately accountable for their own performance (DHCC 1996a:19).

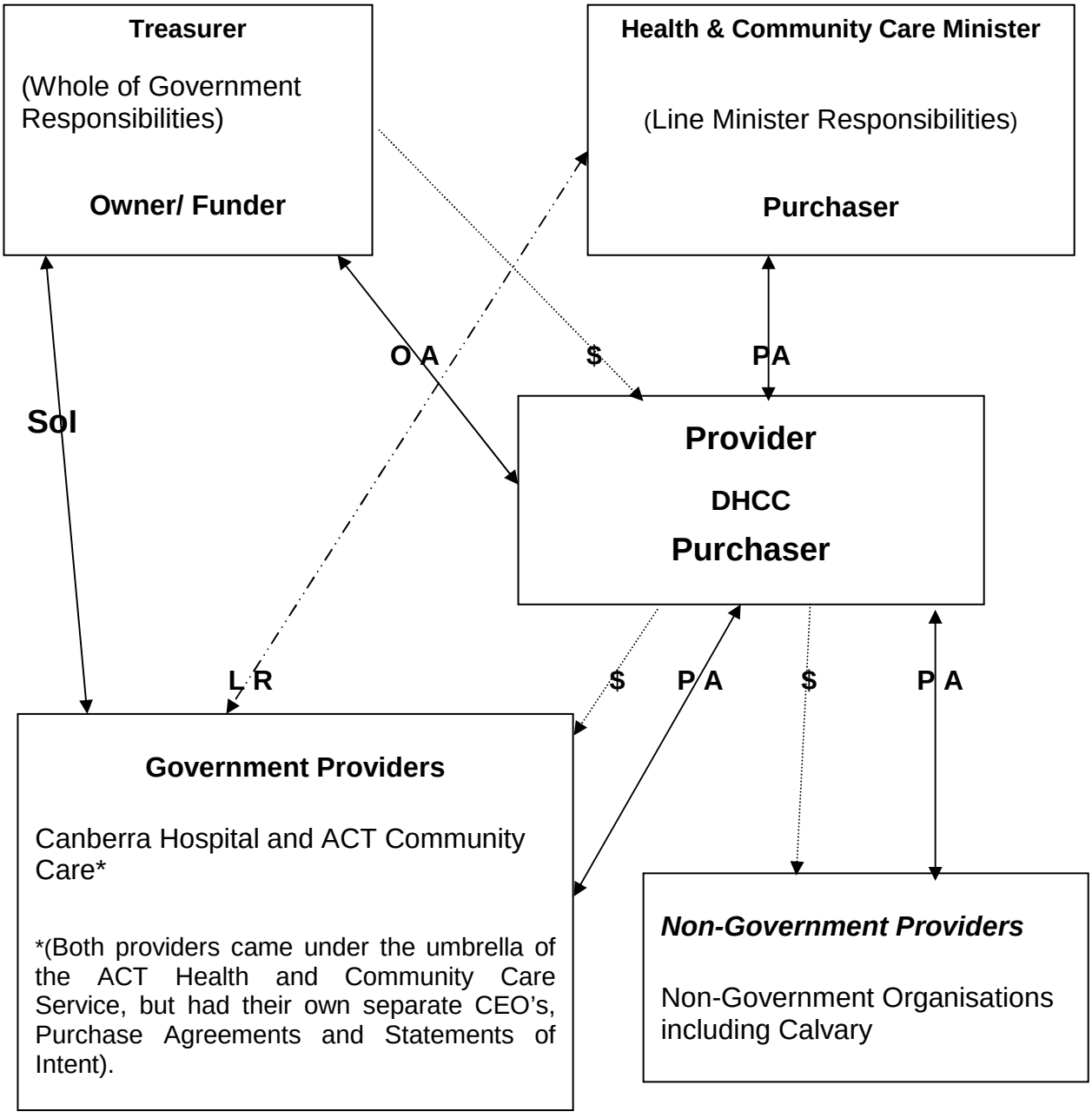
A diagram which shows the major arrangements associated with the use of the PPM in the health area in ACT is in Figure 3.1. It shows that:

- The Treasurer's owner funding role was reflected in:
  - an ownership agreement with and funding provided to DHCC; and
  - a statement of intent (an ownership type agreement) with government providers;
- The Health Minister had:
  - a purchasing role in regard to the activities of DHCC that was reflected in a purchase agreement with the CEO of DHCC; and
  - legislative responsibilities for ACTHCCS and its subsidiaries (TCH & ACTCC).
- DHCC was:
  - a provider of services to the Health Minister; and
  - a purchaser of services from government and non-government providers through a purchase agreement with them, and through payment arrangements.

Figure 3.1

ACT PURCHASER PROVIDER MODEL: ARRANGEMENTS FOR HEALTH AND COMMUNITY CARE SERVICE PROVISION

Major Contractual, Funding, and Other, Formal Relationships



Abbreviations: **P A** = **Purchase Agreement Contract**,
O A = **Ownership Agreement Contract,**
SoI = **Statement of Intent (Ownership Type Contract),**
$ = **Flow of Funds,**
. **L R** = **Legislative Responsibility.**

SUMMARY

The ACT provides a range of public health services as part of its state and territorial responsibilities. While the majority of its services are provided to ACT residents, some important services are provided to people in the area surrounding the ACT on a somewhat controversial arbitrated cost recovery basis. The introduction of self-government into the ACT in 1988 placed considerable pressure on the ACT to bring per capita costs of health services and especially hospital costs, which consume about 65% of the ACT Government's expenditure on health service provision, into line with costs in the States. A purchaser/provider type approach was seen as in line with then-current trends, and offering some potential to bring health expenditure under control.

The reforms that were developed were influenced by a desire of the ACT Government to take action in accordance with developments elsewhere. They also reflected a degree of naivety and inexperience. The administrative architecture (especially the configuration of role and role relationships, resource allocation arrangements and a performance management framework) that was developed as part of the PPM often made the public policy goals that the ACT Government sought, difficult to implement. This will be illustrated in greater detail in later Chapters. In the next Chapter the methodology used in this thesis is outlined and justified.

Chapter 4

Methodology

In this Chapter the methodology used in the research for this thesis is outlined and justified. In this thesis the PPM was expressed in terms of three important components of the administrative architecture through which public policy for the provision of health services in the ACT was expected to be implemented. To address the research questions and the thesis proposition, the research methodology involved the use of:

- qualitative research methods;
- a case study approach;
- semi-structured interviews, documents and the academic literature as the major data sources;
- purposive sampling as the main form of non-probability sampling; and
- multiple sources of data to provide triangulation of results.

QUALITATIVE RESEARCH

A qualitative research approach was used in this thesis because, inter alia, it was generally seen by academic researchers as being well suited to the study of the implementation process (Rist 2001:261), even though, there was no general consensus on the boundaries and contents of research methods using qualitative data (Gabrielian 1999:178). Furthermore qualitative research is increasingly seen as more interpretative, geared more towards understanding than explaining (Gabrielian 1999:174), with a number of benefits because of its flexibility, which allows:

- approaches to observation that are more unstructured than quantitative approaches (Babbie 1998:345; Punch 1998:185);
- sampling that evolves rather than being pre-specified (Miles and Huberman 1994:27); and
- data collection and analysis to go hand in hand (Taylor & Bogdan 1998:141).

In handling data using qualitative research methods, the process of data analysis is iterative allowing the researcher to shift between cycles of inductive data collection and analysis to deductive cycles of testing and verification (Gabrielian 1999:175&199; Huberman & Miles 1994:438). Furthermore, because the reduction of data into a manageable model is the

end goal of qualitative research, the flexibility of the methodology allows the researcher to develop working models during the research to explain the behaviour being studied (Janesick 1998:46). In this thesis the following modelling of the administrative architecture was used to allow qualitative data to be collected and analysed in a manageable form.

An overall model

As noted in Chapter 2, in order to simplify the research approach the thesis concentrated on the following three major components of the administrative architecture:

- the configuration of role and role relationships;
- resource allocation arrangements; and
- the performance management framework.

Furthermore for each of the above components of the administrative architecture was expressed in terms of:

- Goals;
- Means; and
- Expected outcomes (goals expressed in more specific detail).

Taking the above approach provided a framework that not only allowed the major expected outcomes to be compared with actual outcomes, it also provided a framework that:

- included a set common concepts for each component of administrative architecture considered;
- allowed the relevance of the goals and the means that underpinned the expected outcomes to be identified; and
- assisted the thesis analysis in Chapter 8 by allowing goals, means and actual outcomes to be linked.

The extended representation of the administrative architecture referred to above is illustrated in tabular form in Table 4.1.

Health Sector Data

To undertake analysis of data related to the provision of health services in the ACT during the PPM period, the goals, means and expected outcomes were expressed in specific terms.

Table 4.1

AN EXTENDED REPRESENTATION OF THE ADMINISTRATIVE ARCHITECTURE FOR IMPLEMENTING PUBLIC POLICY
A Framework for Analysis

The configuration of role and role relationships:	Resource allocation arrangements :	The performance management framework:
• **Goals**	• **Goals**	• **Goals**
• **Means**	• **Means**	• **Means**
• **Expected outcomes**	• **Expected outcomes**	• **Expected outcomes**

First, as discussed in more detail in Chapter 5, for the configuration of role and role relationships, the goals of using the PPM were to:

- clarify roles and role relationships;
- to reduce opportunities for capture;
- provide a more autonomous (and contestable) role for providers; and
- provide an enhanced role for consumers.

The means of achieving this were through: the separation of roles with different purposes; an arm's length relationship between the political and management roles, and purchasing and providing roles; the use of a policy of letting managers manage; greater involvement of consumers; and giving purchasers a proxy consumer role to ensure that consumer interests were not dominated by those of providers. The expected outcomes were:

- clear roles and role relationships;
- the minimisation of opportunities for capture;
- an autonomous (and contestable) service delivery role for providers; and
- a more meaningful and involved role for consumers.

(ACT Chief Minister's Department 1995a:2-3; DHCC 1995:15; Personal Communications; SCFPA 1999:20; Weeks & Anderson 1995:14-16 & 40).

Second, in regard to resource allocation arrangements, that are discussed in more detail in Chapter 6, the policy goals associated with the use of the PPM were to achieve greater value for money and cost constraint by only purchasing goods and services necessary to meet the government's desired outcomes, and especially those that were in line with the needs of consumers and at contestable prices. The planned means of achieving this were through:

- the clear specification of purchase requirements, that were related to outputs and specified in contracts;
- contestable procurement arrangements; and
- consumer focused needs analysis.

In terms of outcomes these arrangements were expected to provide: a clear specification of purchase requirements in terms of outputs; goods and services that more closely met consumer's needs, and more cost effective service provision (ACT Government 1995a:5; ACT Chief Minister's Department 1995b:5; DHCC 1996b:11 &13; Weeks & Anderson 1995:4, 14-15 & 41).

Third, in regard to the performance management framework, which is discussed in more detail in Chapter 7, the policy goals associated with the PPM were to: achieve greater performance objective clarity, especially for government entities; provide a more formal basis for performance management; highlight the strategic importance of what organisations do; use a managerial approach to performance management; and to provide meaningful performance measurement. The expected means of achieving this were to be:

- the separation of ownership and purchasing objectives for government instrumentalities;
- the use of contracts to specify performance objectives;
- the specification of performance in terms of outputs;
- a managerial accountability approach; and
- the use of performance measures that had a clear purpose and were meaningful in number.

The expected outcomes were:

- greater performance objective clarity with agreed directions and priorities;
- more transparent performance objectives;
- accountability for achieving results; from those with designated authority; and
- improved performance as the result of more useful performance measures.

(ACT Chief Minister's Department 1996:10-21; Scott 1996:33; Weeks & Anderson 1995:4, 21, 25-26, 29 & 58-59). The above framework is summarised in tabular form in Table.4.2.

Table 4.2
THE FRAMEWORK USED TO ANALYSE THE IMPACT OF USING THE PPM IN THE HEALTH SECTOR IN THE ACT
By Major Components of the Administrative Architecture and Related Characteristics

Role and Role Relationships	Resource Allocation	Performance Management
A. Goals		
• Clarify roles and relationships;	• Greater value for money and cost constraint;	• Clear performance objective specification, especially for government agencies;
• Reduce opportunities for capture;	- By only buying goods and services necessary for government outcomes, and especially those that were in line with the needs of consumers and at contestable prices.	• A more formal performance management basis; • Highlight strategic importance of activities; • Adopt a managerial approach to performance management;
• More autonomous and (contestable) role for providers;		• Provide meaningful performance measurement.
• Provide enhanced role for consumers.		
B. Means		
• Role separation, with arm's length relationships that avoided capture;	• Through clear specification of purchase requirements related to outputs and in contracts;	• Separate ownership and purchase objectives of government entities;
	• Consumer focused needs analysis;	• Use contracts to specify and control performance;
• Policy of "letting managers manage";	• Contestable procurement arrangements.	• Specify performance in output terms;
• Involving consumers more and giving purchasers a proxy consumer role.		• Use a managerial accountability approach;
		• Use performance indicators that had a clear purpose and were meaningful in number;
C. Expected Outcomes		
• Clear roles and role relationships;	• Clear specification of purchase requirements in terms outputs	• Greater performance objective clarity, with agreed directions and priorities;
• Opportunities for capture minimised;	• Goods and services that more closely met consumer needs	• More transparent performance objectives;
• Autonomous and contestable providers;		• Accountable for achieving results from those with designated authority;
• Meaningful and involved role for consumers.	• More cost effective service provision	• Improved performance as the result of more useful performance measurement;

Source: ACT Chief Minister's Department 1995a:2-3 & 1995b:5; ACT Chief Minister's Department 1996:10-21;ACT Government 1995a:5; DHCC 1995:15 & 1996b:11 &13; Personal Communication; Scott 1996:33; SCFPA 1999:2; Weeks & Anderson 1995).

THE CASE STUDY APPROACH

Miles and Huberman (1994:25) have defined a case 'as a phenomenon of some sort occurring in a bounded context', while Creswell (1998:61) consider a case study to be 'an exploration of a "bounded system" or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context.' Berg (2004:251) notes that the case study approach is used by many qualitative investigators to guide their research. As Yin (2009:8-10) indicates, "how" and "why" questions are well suited to case study analysis. Moreover, Yeager (1998:809) points out that case study research is one of the most widely used research techniques in public administration, in part, because case studies allow a wide variety of evidence to be considered (such as documents, interviews, and observations) and for a range of data sources to be used to validate findings (Bradshaw et al. 1998:213; Creswell 1998:62). Also, Yin (1994:3) argues that case studies 'allow an investigation to retain the holistic and meaningful characteristics of real-life events', such as organisational and managerial processes. Consequently, in this thesis the case study approach has been used because it allowed a wide range of information rich evidence to be used, and also allowed issues to be examined in a more holistic manner.

Case Study Design

According to Punch (1998:153) two characteristics define a case study design: there is a specific focus which has the explicit aim of preserving the wholeness, unity, and integrity of the case; and multiple sources of data and multiple data collection methods are likely to be used. On the other hand, Yin (2003:40) distinguishes case study designs along two axes of a matrix. On one axis there are single and multiple cases, and on the other axis there are holistic and embedded cases. In the context of Yin's matrix design, this study was a single case study in that it looked solely at the administrative architecture through which public policy was implemented in the health area in the ACT by representing the PPM used as an administrative architecture. It was also an embedded case study in that separate consideration was given

to issues related to role and role relationships, resource allocation and performance management, which were the embedded units of analysis.

Yin asserts that the validity of case study design can be addressed by the use of the following four tests:

- *Construct validity*: establishing correct operational measures for the concepts being studied ;
- *Internal validity:* (for explanatory or causal studies only and not for descriptive or exploratory studies): establishing a causal relationship, whereby certain conditions are seen to lead to other conditions, as distinguished from spurious relationships;
- *External validity:* establishing the domain to which the study's findings can be generalized; and
- *Reliability:* demonstrating that the operation of a study – such as the data collection procedures – can be repeated, with the same results (Yin 2009:46).

In this thesis, as discussed in more detail elsewhere in this Chapter, construct validity was addressed by using multiple sources of data, which included semi-structured interviews, documents, and the literature. Such a multi-method approach is often referred to as "triangulation" (Guba & Lincoln 2005:722). Yin (2009:114-115) considers that triangulation through the use of multiple sources of data is more important in case study research than with other research methods, and Janesick (1998:47) notes that triangulation is meant to be a heuristic tool and not limited to three perspectives as the name implies. In this thesis, construct validity was also assisted by the use of observation, and the use of respondent validation; a cross-checking of information by asking a number of people to comment on the findings of the research. This was helpful to the researcher as in some instances the people contacted were able to point out deficiencies in the data used and/or to refer to sources of additional data.

Internal validity issues were addressed in this thesis by using a form of pattern matching logic which is discussed later in this Chapter. External validity (or the generalisability of the results) was addressed by limiting the domain to which the thesis findings were to be generalised, identifying the extent to which case was representative and through the use of analytic

generalisation (issues considered further in Chapter 9). Reliability was addressed through the use of a methodology that contained approaches that were widely used, and were repeatable.

Case Study Types

Yin (2009:8) and Berg (2004: 256-257) classify case studies as exploratory, descriptive, or explanatory, whereas, Stake identifies three types:

- intrinsic studies, where the interest is in the case itself;
- instrumental studies, where a particular case is studied to provide insight into an issue or refinement of a theory; and
- collective studies where a number of cases are chosen because it was believed that understanding them lead to a better understanding and possibly better theorizing about a still larger collection of cases (Stake 1998:88-89).

However, Stake notes that there is seldom a neat fit into this classification, which is heuristic rather than functional.

In terms of Yin's categories this case study was both descriptive and explanatory. It was descriptive in the sense in that it described the policy goals and the impact of the means used for each of the major components of the administrative architecture It was explanatory in that it provided evidence not only to support the thesis proposition but also to explain why the administrative architecture through which public policy is implemented plays a crucial part in its implementation. Consequently the case study was, then instrumental in terms of Stake's classification and explanatory in terms of Yin's typology.

Case Study Methods of Analysis

Case study methods of analysis involve examining, categorising, tabulating, testing or otherwise recombining evidence to address the study propositions. Techniques that are suggested for analysing case studies included: pattern matching, explanation building and time-series (Yin 2003:109). The approach taken in this thesis was a modified form of pattern matching logic.

Pattern Matching Logic

Pattern matching is a form of logic that involves comparing an empirically based pattern with a predicted one (Yin 2003:116). While Yin sees the

technique as one of most desirable for case study analysis, he notes that ‘At this point in the state of the art, the actual pattern-matching procedure involves no precise comparisons’ (Yin 2009:140). Therefore, the researcher has considerable latitude in regard to the predicted pattern that is developed. In this thesis pattern matching involved comparing predicted (expected) patterns from the representation of the PPM as an administrative architecture with the actual pattern evidenced by data from interviews and documents (the empirically based pattern). In regard to data relating to the actual pattern, Table 4.2 and the arrangements in Figure 3.1 (drafts of which were developed prior to the beginning of the interview process largely from information in pre-existing documents) provided the overall basis for both collecting data through semi-structured interviews and from documents and for analysing the data. Table 4.2 provides a template of the predicted pattern and a basis for matching (or rather making comparisons between) this pattern and what actually happened. These comparisons then provided the basis for analysis and enabled a clearer assessment of the research questions.

In this thesis the actual pattern was considerably different from the predicted pattern and as shown in Chapter 8 there was adequate evidence to support the view that as an administrative architecture for the implementation of NPM-type policy in the ACT health area was inappropriate. Given that result, the next process was to asses whether there was adequate evidence to indicate that this inappropriateness supported the thesis proposition that the administrative architecture through which public policy is implemented plays a crucial part in the implementation of that policy.

An alternative approach to the analysis would have been to use what is referred to as a null hypothesis approach (Babbie 1998: 57), by trying to find evidence to support the view that the (null) hypothesis that the administrative architecture through which public policy is implemented does not play a crucial part in its implementation is false. However, such a direct approach would have been more difficult and appeared to be more suited to quantitative analysis.

DATA NEEDS AND DATA SOURCES

In this thesis (as noted earlier) qualitative research was used. In this approach research is not as focused at the beginning on data needs as quantitative research is. This is because one of the major aims of qualitative research is to maximize opportunities for the researcher to learn from research participants and to develop a depth of understanding (Bouma 2000:178; Yeager 1998: 814). Ongoing decisions about future data collection strategies are often guided by the preliminary analysis of data. Also as Yin (2003:61) notes, when unanticipated events occur, the researcher has to be willing to adapt procedures or plans.

In this thesis, data needs were modified over the course of the study as preliminary analysis of the data occurred and as greater insights into a range of issues were gained. Data needs and data sources were driven by the need to understand the impact of using the PPM, and the reasons why, as an administrative architecture for implementing public policy, it had a number of shortcomings.

Data used for analysis in this thesis was predominantly derived from a number of semi-structured face-to-face interviews, and a range of documentary sources. In addition, in some instances use was also made of personal observations. Interviews as a data source have been used throughout the history of public administration research (Yeager 1999:823). Yin (2009:103) asserts that documentary information has an explicit function in any data collection for a case study, with its most important use being to corroborate and verify evidence from other sources. However, Atkinson and Coffey (2004:58) claim that documentary materials can be regarded as data in their own right and suggest that it was vital to give documentary data due weight and appropriate analytical attention. In this thesis, considerable use was made of documentary data as it provided an important source of primary data as well as corroborating and verifying other evidence. More specific details of the interviews undertaken and the documents accessed are provided below.

Interview Data

Interview data for this thesis was collected from senior government officers, government officers involved with the purchasing function, government and non-government providers, consumer group representatives, and representatives of other groups on which the PPM impacted.

Data was derived from semi-structured interviews and discussions with 90 individuals, viz.:

- The ACT Minister for Health and Community Care after 1998;
- Two CEOs of the Department of Health and Community Care, and a number of other officers of the Department;
- The Chairman and several other members of the ACTHCCS Board;
- Senior representatives of the ACT Treasury and Chief Minister's Department;
- Representatives of ten peak organisations associated with health issues;
- Three people who undertook consultancy activities associated with the health sector in the ACT;
- The CEOs of TCH and Calvary hospitals, a number of administrative staff and clinicians associated with these hospitals;
- The CEO of John James Memorial hospital, and a representative of one of the other hospitals that won a tender during the period of the PPM;
- The CEO of ACTCC and other staff of ACTCC;
- Representatives of organisations that received funding from the DHCC for the provision of community care services during 2000-2001, and a small number of other individuals. Of these interviews, 34 were with representatives of non-government organisations that received government resourcing under one or more of the 10 programs associated with community care services in 2001-2002 (Aids and Hepatitis C, Alcohol & Drug, Community Health Support, Health Strategy and Acute Services, Aged Care, Disability Services, Home and Community Care, National Women's Health, Youth Health Services, and Other.);
- The Director of the Mental Health and Corrections Health Unit of DHCC and staff members, ACT Mental Health Service (ACTMHS), organisations that received funding as part of the Mental Health Program from the DHCC for the provision of mental health services during 2000-2001, and a small number of other individuals; and
- Information was also available from interviews I undertook in 1996 and 1997 as part of two small studies of issues associated with the use of the PPM in the ACT.

Documentary Sources of Data

In this thesis, documentary sources used included a range of annual reports, contracts, ACT Budget papers, legislation, reports and academic literature, including:

- Annual Reports of DHCC and the Health and Community Care Service;
- Annual Reports of Calvary Hospital ACT Incorporated;
- Purchase Agreements between DHCC and the major providers, viz. TCH, Calvary, and ACT Community Care (ACTCC);
- ACT *Financial Management Act 1996* and associated Explanatory Memorandum;
- ACT *Health and Community Care Service Act 1996* and associated Explanatory Memorandum;
- Statements of Intent between the Treasurer with TCH/ACTHCCS board and ACTCC/ACTHCCS board;
- A number of other policy documents; and
- In regard to most non-government providers other than Calvary, documents accessed included the latest annual report of the organisation at the time of interview and in most cases extracts from contracts relating to the services they provided to DHCC.

METHODS OF DATA COLLECTION

Data was collected through the use of interviews and the analysis of documents.

Interviews

In undertaking interviews, the following four major decisions were addressed:

- what type of interviews were to be undertaken;
- what type of respondent sampling was to be undertaken;
- what size of sample was to be used; and
- how were interviews to be recorded.

The alternatives for the type of interview to be undertaken are: structured, unstructured, and semi-structured. Structured interviews are seen as useful when there is a lot of information available about a topic and there is a clear and definite range of answers that could be obtained by addressing a standard set of questions to all participants or sets of participants (Easterby-Smith et al. 1991:72; Kayrooz & Trevitt 2005 193; Taylor & Bogdan 1998:88). Unstructured and semi-structured interviews are appropriate when the interviewer wishes to understand the constructs used by the interviewee as a basis for beliefs and opinions about a particular matter or situation (Easterby-Smith et al. 1991:74). An unstructured interview is non-standardised, open-ended, and in-depth, and is often used to obtain details of the complex behaviour of people without imposing any constraints that might limit the field of inquiry (Punch 1998:178). However, Easterby-Smith et al. (1991:75)

warned against assuming that unstructured interviews were the way to produce a clear picture of the interviewee's perspective.

A semi-structured interview is an interview built around a set of topics rather than fixed wording (Kayrooz & Trevitt 2005:194-195). With such interviews the questions asked in each interview are not necessarily the same, and are likely to differ in significant ways depending on the different positions and experience of each interviewee (Yeager 1998:823). Because semi-structured interviews undertaken as part of a qualitative research approach allowed flexibility, and an iterative data collection and analysis process, they were used in this thesis. For each interview in this study, lists of topics to be covered in the interview were developed. This list which was based on matters in Table 4.2 and Figure 3.1 often varied from interview to interview depending on the position and experience of the interviewee. However, for non-government providers (other than Calvary) use was also made of a sheet that contained a list of common interview topics that were listed under the categories:

- role and role relationships;
- resource allocation; and
- performance management. (See Appendix C).

While interviews were focussed on the research issues, interviewees were not constrained from either raising other topics and issues, or commenting on or putting more emphasis on issues and topics of importance to them.

The use of semi-structured interviews provided several benefits. This study was undertaken as an outsider and with typically limited knowledge of several aspects of the provision of health services in the ACT, and the use of such interviews in this thesis provided a vehicle to assist in the process of improving this knowledge and gaining rapport with interviewees. The use of semi-structured interviews also allowed interviewees to express their views at the same time as the information sought was being obtained. In some instances the interviewees raised important issues that had not been previously considered, and which formed the basis for further consideration. In addition, the use of this method of interviewing provided a basis for

identifying additional potential interviewees and documentary sources of data appropriate to the study. However, as semi-structured interviews tend to take up more time than structured interviews, care had to be taken to ensure that issues relevant to the thesis were addressed within a reasonable time frame. In this study, an attempt was made to ensure that interviewees were aware (either by phone or in writing) of the topics that needed to be covered and that interviews were expected to take no longer than one hour. Most interviewees were able to provide that amount of time. However, it was not uncommon to find that even where interviewees had been given prior written information about topics and issues to be covered, this information had not been read prior to the interview.

Two major means of undertaking semi-structured interviews are the use of face-to-face and telephone interviews (Yeager 1998:823). deVaus (1995:109) suggests that the face-to-face approach is best for complex questions, and Yeager (1998:824) sees face-to-face interviews as having a number of advantages:

- it can be easier to gain rapport with the interviewee;
- it is more difficult for the interviewee to terminate the interview;
- the technique allows more personal interaction between the interviewer and the interviewee to take place; and
- they often allow more complete data to be obtained.

Overall, he considers that face-to-face interviews are more effective than those using a telephone, because they result in:

- a higher response rate;
- longer interviews;
- fewer unanswered questions,
- more answers to open ended questions; and
- a more enjoyable environment for the interviewee.

In this study, the majority of interviews were face-to-face. However, in some instances telephone interviews were used as they were the only manner in which some information could be obtained.

Sampling

The two major alternatives for respondent sampling are probability and non-probability sampling (Babbie 1998:194-196). Probability (random sampling) is

largely used where representative samples are sought and/or where the aim is to determine average populations or statistical significance (Babbie 1998:194; Becker 1998:70; Miles & Huberman 1994:27). However, as this is not the aim of case studies (Yin 2003:48), the use of such sampling methods was deemed inappropriate.

Major forms of non-probability sampling are snowball sampling, quota sampling, and purposive or judgmental sampling, (Babbie 1998:195-196). Snowball sampling is undertaken by collecting data from a few members of the target population then asking them to assist in locating other members of the population (Babbie 1998:195). It is seen as an appropriate method when the interviewer is not sure who is the appropriate person to see about a specific issue, but it has the potential to introduce bias (Babbie 1998:196). Under quota sampling individuals are selected to ensure that an appropriate proportion of the population is included in the sample, or that individuals in the sample are appropriately weighted to reflect their proportion in the population (Babbie 1998:196).

Purposive sampling is a procedure where the researcher selects the sample on the basis of knowledge of the population and purpose of the research (Babbie 1998:195; Kayrooz & Trevitt 2005:159). It is a form of sampling that depended on emergent design rather than on *a priori* design, and requires a procedure that is governed by emerging insights about what is relevant to the study based on the focus determined by the problem, and purposively seeks both typical and divergent data to maximize the range of data about the context (Erlandson 1993:148). Qualitative samples tend to be purposive (Miles & Huberman 1994:27; Punch 1998:193). As a sampling method purposive sampling often enhances the research by finding people with different perspectives on key issues, and is seen as the preferred method when the aim is to maximize the discovery of heterogeneous patterns and problems (Easterby Smith et al. 1991:64; Erlandson et al. 1993:82).

In this study, all three methods of non-probabilistic methods of sampling were used to varying degrees. Purposive sampling was the main form of sampling

used. However, in relation to some issues a degree of snowballing was used, because as an outsider, it was not always obvious who was the appropriate person to see, and some interviewees were more willing to participate when it was known someone they respected suggested they be interviewed. As Kayrooz and Trevitt (2005:190) suggest key informants often provide a pipeline to groups that are critical to the success of the research. Furthermore, in addressing issues related to non-government providers of community care services, an elementary form of quota sampling was used to the extent that at least one representative of each of the nine programs funded by DHCC was interviewed.

Sample Size

With both purposive and snowball sampling the sample size was not predetermined, but was influenced by the level of variability in issues and views expressed. As suggested by Erlandson et al. (1993:91), respondents are determined on the bases of what the researcher desires to know, and of what they can contribute to the understanding of the phenomenon under study. The size of the sample in this thesis was determined towards the end of the research not at the beginning. In the absence of any other constraints, and in line with the view of Erlandson et al. (1993:148), the decision to stop the sampling process was made when redundancy of information occurred. In this study a substantial number of interviews and discussions were undertaken; being an “outsider” contributed to this.

Interview Recording

Finally, in regard to the method of recording interviews, it was originally planned that interview data would be tape-recorded. However, the first people to be interviewed were anxious about having their views taped so it was decided to take notes during interviews and to write them out in full as soon as possible after the interview. Comments were analysed and relevant comments sorted into categories relevant to the study. Overall, interviewees appeared to be more willing to express their views on sensitive aspects associated with the use of the PPM when they knew that their views were not being tape-recorded.

Documents

It was possible to obtain either full printed copies or photocopies of documents that provided the data for analysis in this thesis. As with interviews a degree of purposive sampling was used as part of the document collection process. In one instance a lengthy document related to ACT hospital funding was provided in the form of a compact disc. In some instances documents were provided by respondents at the time of interview. While one interviewee suggested that some information be obtained under Freedom of Information provisions, this was not seen as necessary because of the adequacy of the information in other documents and interviews.

LIMITATIONS OF THE METHODOLOGY

The methodology used in this thesis was not without limitations. There were limitations:

- in using qualitative research;
- associated with the use of a single case study;
- in using purposive sampling;
- resulting from the use of note taking:
- because some people refused to participate;
- resulting from data credibility; and
- participant inexperience.

As noted earlier, Gabrielian (1999:193), suggests there is a lack of universally accepted criteria for judging the soundness and goodness of qualitative research. It is seen as a methodology associated with the post positivistic approach in which there is greater tolerance for error, the findings that are produced are regarded as probable and considered true until falsified rather than established (Gabrielian 1999:177).

The use of single case studies is seen as limiting the generalisability of results (Punch 2005:145; Yeager 1998:811). However, Yin (2009:47-50) identifies five rationales for using single case studies. A single case study is seen as appropriate where it represents a:

- critical case for testing a well formulated theory;
- unique or extreme case;
- representative or typical case;

- revelatory case that provided an opportunity to observe and analyse a phenomenon previously inaccessible; or
- longitudinal case.

In this thesis the case analysed had attributes of a representative case. Also the generalisability of the results was further addressed by identifying the domain of the findings, and by the use of analytic generalisation (This issue is discussed further in Chapter 9).

There was no objective measure for assessing whether the level of purposive sampling was adequate. In the area of management research, access to information from managers by outsiders can be difficult because decisions as to what information is provided can be influenced by political considerations, the busy work load of potential respondents, and concerns about the purposes for which the information may be used (Easterby Smith et al. 1991:5 & 44-45). In this study a small number of middle-level departmental staff, hospital staff and others refused to participate. While the concerns mentioned above appeared to influence the decisions of some, other reasons included an aversion to helping university students with their theses, and a lack of interest in an approach the ACT Government was seen as abandoning. Overall the lack of participation by these people had limited impact on the results.

In this thesis notes were taken during interviews, but notes can only provide a record of major points, and quotes are sometimes lost (Yeager 1998:837). However, the focus of the study was on issues rather than the individual comments of respondents, and bias in recording data was offset by also using documentary data sources and respondent validation. In addition, because of the wider applicability of the model developed (see Table 4.1) the pattern matching process in this thesis provides a basis for replicating the study.

In regard to the credibility of information, a number of limitations have been noted in relation to interviews. The use of interview techniques did not guarantee the accuracy of the information provided. Interviews were subject to the same distortions and exaggerations that characterise conversations between people. Also as time passed people not only forgot events, persons and details, but also telescoped events (Taylor & Bogdan 1998:91 & 98;

Yeager 1998:835). These issues, which often had greater impact on outsiders, were addressed by supplementing interview information with documentary information and by undertaking a substantial number of interviews, many of which occurred during the period the PPM operated.

Another limitation was the credibility of data. Taylor and Bogdan (1998:91) assert people say and do different things in different situations and there was some evidence of this in the research interviews and in particular it appeared that the comments of respondents were often influenced by major issues at the time of the interview. While many interviewees appeared to provide frank comments during the period in which the PPM operated, some interviewees appeared to be more open after the PPM was abolished. Finally, staff turnover and lack of experience with pre-PPM arrangements limited the range of issues that could be addressed with some respondents. Again these limitations were offset by the use of triangulation.

SUMMARY

The use of a qualitative methodology increased the flexibility of the study, and the use of a case study approach provided an understanding of important aspects of the problem and allowed the study to be undertaken in a bounded context with the use of a form of pattern matching logic provided a major basis for the analysis of the case study data.

Semi-structured face-to-face interviews, the academic literature, and documents provided the main multiple sources of evidence. The use of multiple sources of evidence (often referred to as triangulation) was seen as both a strength and a necessity in case study research, helping to improve the validity of the research and clarify meaning by providing multiple perceptions of the case (Stake 2005:453-454). While purposive sampling was the main form of sampling used in this thesis, as an outsider some reliance was also placed on snowball sampling.

The research methodology was not without its limitations. The major limitations that were addressed were the use of:

- qualitative research;
- single case studies;
- purposive sampling; and
- note taking.

The validity of the case study design was addressed by using the following four tests identified by Yin (2009:40): construct validity, internal validity, external validity, and by testing the reliability or repeatability of the design. Also, while case studies such as this one require further research to enhance their generalisability, the generalisability of the findings of this study was addressed by using a case that was representative in nature, identifying the domain of the findings, and by the use of analytical generalisation. In the next Chapter, data is provided relating to the configuration of role and role relationships that form part of the administrative architecture.

Chapter 5

Role and Role Relationships

This is the first of three Chapters providing empirical data to support the thesis argument that the administrative architecture through which public policy is implemented plays a crucial part in the implementation of that policy. As noted earlier in the thesis, the PPM is expressed as three major components of the administrative architecture:

- A configuration of role and role relationships;
- Resource Allocation arrangements; and
- A performance management framework.

While no formal rules were used to decide which interview and documentary data were included in Chapters 5, 6 and 7, the decision was influenced by the data's relevance to the research issues being considered, and the need to provide appropriate diversity of data. Also, for interview data the status and/or experience of the interviewee was an important factor.

This Chapter provides data related to issues associated with the configuration of role and role relationships that were part of the PPM approach and consequently part of the administrative architecture it was designed to develop. Data relating to resource allocation arrangements, and the performance management framework are in Chapters 6 and 7 respectively. The detailed analysis of the data in Chapters 5, 6 and 7 and related comment in the Literature Review (Chapter 2), is in Chapter 8. In particular this Chapter provides data on:

- The use of role separation to clarify -
  - ownership and purchasing roles, and
  - purchaser and provider roles;
- The provision of greater autonomy to providers;
- The provision of a more contestable roles for providers; and
- An enhanced role for consumers, which included the purchaser undertaking a proxy consumer role.

In addressing each of these issues, the Chapter provides an overview of the policy goals, the nature of the arrangements (the means and instruments used to achieve these goals), and the impact of arrangements during the

implementation process (the impact of the policy goals and means and instruments used). In brief, the data show that:

- the role separation arrangements used were seen by interviewees as creating some unnecessary forms of separation, and confusing rather than clarifying roles and relationships;
- the autonomy arrangements in place were seen by interviewees as giving government providers too much role flexibility and were a source of tension with DHCC;
- the use of role delineation and other constraints largely limited the contestable role to providers in the non-government sector, where there was a concern about the impact of competition on cooperation; and
- there was a significant gap between the rhetoric and the action taken to provide an enhanced role for consumers.

ROLE SEPARATION

While role separation had objectives such as reducing provider capture (discussed later), under the PPM, role separation arrangements were largely designed to provide greater role clarity by distinguishing between ownership, purchasing, and providing roles (ACT Chief Minister's Department 1995a:2). Compared with arrangements in place prior to the introduction of the PPM, the major changes in role and role relationships following the implementation of the PPM were the provision of separate:

- ownership and purchasing roles; and
- purchasing and providing roles.

Separation of Ownership and Purchasing Roles

Policy Goals

The separation of ownership and purchasing roles was designed to distinguish between the ownership and purchasing activities of government. The aim of the ownership role was:

> to ensure that there is optimum investment in each agency and that each agency's financial performance meets targets set by the owner (ACT Chief Minister's Department.1996:10).

This role was seen as analogous to the controlling shareholder interests of a private sector company, concerned with the efficient operation of an agency (Weeks & Anderson 1995:15). In contrast, the aim of the purchasing role was to acquire goods appropriate to the needs of government, delivered at the

right time, and at the lowest possible price (Weeks & Anderson 1995:14-15). It was a role designed to ensure a more business-like approach to service delivery, that resulted in the minimum number of appropriate and efficiently produced outputs being purchased to achieve the desired outcomes of the ACT Government (ACT Chief Minister's Department.1996:10). More specifically, it was designed to give the Minister and DHCC the role of ensuring that the services purchased were consistent with output appropriations in the ACT Budget (ACT Government 2001f:3).

Nature of Arrangements

Under the role separation arrangements put in place in the ACT as part of PPM arrangements, Treasury had the ownership role, and the purchasing role rested within the Health and Community Care portfolio. As part of purchasing role arrangements the Minister had a purchase agreement with the CEO of DHCC, and DHCC had purchase agreements with providers.

The provision of an ownership role for Treasury resulted in it being given a broad economic management role. Its role in relation to line/functional departments moved from one of financial control to one of monitoring and analysis. It undertook the role of assisting Ministers with functional responsibilities, such as health and community care, to monitor key elements of PPM arrangements (interview comment: senior executive Treasury).

As part of the ownership role, the Treasurer developed contractual relationships with both DHCC and government providers (TCH and ACTCC) through the Board of ACTHCCS (the Board). The contractual relationship between the Treasurer and the CEO of DHCC was reflected in an ownership agreement. On the other hand, for most of the PPM period, the relationship between the Treasurer and the CEOs of TCH and ACTCC was reflected in Statements of Intent. These statements were provided for in Section 58 of the ACT *Financial Management Act 1996*, which required ACT Authorities (TCH and ACTCC were regarded as such) to each provide a Statement of Intent to the Treasurer. Section 58 of the legislation gave the Treasurer not

only the capacity to seek financial information, but also the capacity to seek information related to the authority's objectives, the nature and scope of its activities, its performance measures and any other information as directed.

Impact of Arrangements

A Policy Perspective

From a policy perspective, the ownership responsibilities of the Health Minister as a line minister were devolved to the Treasurer to ensure that ownership responsibilities were not neglected (interview comment senior executive Treasury). However, such arrangements were unnecessary and ignored the role of the Health Minister. First, the degree of separation that was undertaken appeared unnecessary to avoid ownership responsibilities being ignored. In their report related to arrangements of health in the ACT under PPM arrangements, Weeks and Anderson (1995:21) envisaged that the Health Minister would have both an ownership and a purchase agreement with an organisation such as DHCC. These agreements were to work in conjunction with the financial reports generated by DHCC. Second, role separation arrangements between the Treasurer and government providers ignored the role of the Health Minister in relation to these providers and the responsibilities that flowed from the ACT *Health and Community Care Services Act 1996,* with Sub-Section 14 (1) of that Act stated that:

> The Board shall perform its functions and exercise its powers in accordance with any directions of the Minister.

An Operational Perspective

From an operational perspective, the separation of ownership and purchasing roles created tension between Treasury and DHCC, as DHCC saw no need for a formal ownership relationship between the Treasurer and the CEO of DHCC through the use of an ownership agreement. In particular, the use of an ownership agreement in the PPM was seen by a senior executive in DHCC as a "bastardised" application of New Zealand arrangements and lacking any legislative basis, repeating the same information that was in ACT Budget papers, and having requirements that were adequately covered in the ACT *Financial Management Act 1996* (interview

comments). The responsibilities of the CEOs of ACT Government Departments in Section 31 of the ACT *Financial Management Act 1996* are shown in Appendix D.

The ownership role of Treasury gave the area in Treasury with the role of being responsible for health and community care matters direct links to TCH and ACTCC that did not exist under pre-PPM arrangements. A senior Treasury executive saw advantages in this access from a resource allocation perspective and noted that Treasury would have found it difficult to justify formal contact with TCH and ACTCC but for the requirements of the Statement of Intent (interview comment). While this senior Treasury executive stated that Treasury did not wish to micromanage TCH or ACTCC, a senior executive in DHCC expressed concern that Treasury wanted to have a control role and was not really interested in its ownership role, taking a very passive approach to many aspects of their contractual relationship with providers; focusing on processes rather than the ownership role (interview comments).

While Treasury may not have wanted to control TCH and ACTCC, in two of the interviews undertaken (one with a senior Treasury executive and one with a Board member) the interviewees floated the idea that it may have been appropriate for Treasury to have the role of directly funding TCH and ACTCC. In one of these interviews it was suggested that because funding by output class was finalised at the time of the ACT Budget, DHCC (in its purchasing role) acted largely as a pipeline for the distribution of budget moneys. Such a funding idea would have resulted in Treasury having a purchasing and ownership role. Furthermore it took no account of the role of non-government providers. However, it illustrated the role confusion and tension that resulted from the role separation arrangements in place.

Separation of Purchasing and Providing Roles

Policy Goal

The separation of purchasing, and providing roles was designed to assist the implementation process by providing role clarity, by avoiding confusion and duplication in the conduct of these roles (ACT Government 1996c:iii).

Nature of Arrangements

In the health and community care portfolio this involved role separation between the Health Minister and the CEO of DHCC as well as between DHCC and government providers.

The Health Minister and DHCC

Under the PPM, the Health Minister and the CEO of DHCC were considered to have different roles. The role of the Health Minister was to be responsible for specifying desired policy outcomes and (at a macro-level) the goods and services (outputs) that needed to be purchased to meet these outcomes. The role of the DHCC was to be responsible for policy development, planning and advice, and (particularly in the context of the PPM) to purchase from providers outputs that:

- were within ACT Budget parameters;
- met the policy outcomes set by the Health Minister; and
- best met the needs of the community (ACT Chief Minister's Department 1995a:2-3; ACT Government 2001f:3; ACT Government 2001g:4).

DHCC and Government Providers

There were two sets of relationships: those between DHCC and ACTHCCS, and those between DHCC and the direct government providers (TCH, ACTCC and ACTMHS).

DHCC and ACTHCCS

When the PPM was implemented, the role of DHCC became that of a purchaser with the responsibility for acquiring goods and services. On the other hand, ACTHCCS was expected to undertake the role of overseeing government providers in accordance with the provisions of the ACT *Health and Community Services Act 1996* (ACT Government 1996b:85). However, it was stated in the explanatory memorandum accompanying that legislation that the ACHCCS 'will be a body corporate with wide powers to enable it to perform its functions' (ACT Legislative Assembly 1996a:1). That legislation gave the ACTHCCS broad objectives, Under Section 5 of the Act:

- to provide health and community care services for residents of the Territory that promote, protect and maintain public health;

- to maintain quality standards of health and community care services;
- to take all measures to ensure the efficient and economic operation of its resources; and
- to effectively co-ordinate the provision of health and community care services (ACT Health and Community Services Act 1996: S5).

The broad objectives given to ACTHCCS under its legislation (as is discussed in more detail later in this Chapter) provided it with potential responsibilities that appeared to be far beyond what was the normal role of a provider organisation. As a consequence, the legislation that underpinned the ACTHCCS gave DHCC and ACTHCCS potentially overlapping roles.

DHCC and Government Service Providers

With the implementation of the PPM, role separation arrangements resulted in TCH and ACTCC being put at arms-length from DHCC by placing them under the umbrella of ACTHCCS, but with separate contractual relationships with DHCC through purchase agreement arrangements. Government mental health services previously provided by WVH were transferred to the ACTMHS. Under the transfer arrangements, DHCC became responsible for policy, planning and purchasing activities, and ACTMHS became the government-owned provider, with the executive director of ACTMHS reporting to the CEO of TCH.

Impact of Arrangements

The Health Minister and DHCC

Formal role separation between the Health Minister and DHCC appeared to be meaningless in a small jurisdiction such as the ACT. The Health Minister claimed that the electorate and the media tend to hold the Minister responsible for health and community care outcomes, and that, especially in the ACT, it was difficult to delegate this responsibility. Moreover, it was suggested by a senior executive of DHCC in June 2001 that the government intended to abolish the purchase agreement between the Health Minister and the Department if the PPM was retained (interview comments).

DHCC and Government Providers

DHCC and ACTHCCS

Over time the role separation arrangement that developed between DHCC and ACTHCCS led to considerable conflict between them, especially in relation to their relative roles, as the Board moved to undertake what its members perceived to be its role under PPM arrangements. Both the Board and DHCC saw a need for change. The Board wanted changes to stop DHCC intruding on its role. Whereas DHCC considered that as a result of "naïve good intent" the Board was given a role that was both too broad and inappropriate (interview comments Board members and senior executives of DHCC). As a consequence DHCC sought support for alternative arrangements that were designed to get people to work together, and to address issues such as the perception that clinicians were excluded from a key role in the decision making process because of their lack of ongoing representation on the Board. These arrangements were set out in a draft paper titled *Acute Health Services Plan: putting partnerships into action* (DHHCC 2001). The initial approach by the Board to its role, the later approach of the Board to its role, and concerns about the relative roles of the Board and DHCC (and especially the concerns that arose during the latter part of the PPM period) are in Appendix D.

DHCC and Government Service Providers

The use of role separation between DHCC and government providers as part of arrangements to introduce the PPM resulted in a significant realignment of the role of, and a reduction of, the staff in DHCC, as staff with a provider role moved to government provider organisations (ACT Government 1996b:85). In some instances, the impact of the realignments put in place was to have the same administrative roles undertaken in both the purchaser and the government provider organisations. One Board member noted that under the PPM there were four human resource management areas whereas previously there had been one. This was seen as an unnecessary waste of resources (interview comment).

Another impact of the staff changes associated with role separation was to reduce the level of expertise in some areas of DHCC. One executive noted that because of a lack of expertise in DHCC she had to undertake a DHCC role as part of her duties in ACTCC. A clinical manager in ACTMHS expressed concern that DHCC staff were attending conferences where they lacked appropriate clinical expertise. Moreover, a senior executive in DHCC noted that senior management of ACTMHS was concerned that DHCC did not have the necessary skills to undertake mental health policy, and lobbied for policy planning and service provision to be placed in the one unit (interview comments).

GOVERNMENT PROVIDER AUTONOMY

Policy Goal

One of the major aims of PPM reforms was to provide public sector managers with greater autonomy and flexibility in the management of their business, and to empower agencies to efficiently and effectively manage their resources (ACT Chief Minister's Department 1995a:2; Weeks and Anderson 1995:16).

Nature of Arrangements

When the PPM was implemented, TCH and ACTCC became autonomous government providers: their CEOs became responsible for the day-to-day operations of their organisations, and had such duties as they were given by the Board (ACT Legislative Assembly 1996a:1). However, while ACTMHS became an autonomous provider, its executive director was responsible to the CEO of TCH rather than the Board (ACT Government 1997d:121). The degree of autonomy of ACTMHS from TCH appeared to be somewhat limited. This is illustrated by the fact that in the ACTHCCS Annual report for 1998-99, the ACTMHS was referred to as 'the Canberra Hospital's Mental Health Service' (ACT Government 1999c:62).

Impact of Arrangements

The impact of arrangements put in place meant that TCH and ACTCC could now undertake the role of negotiating what services they would provide, the price for such services, and any other relevant conditions, subject to the

supervision of the Board. However, as ACT authorities, TCH and ACTCC were required to provide, in respect of each financial year, a Statement of Intent to the Treasurer. This statement included a range of financial information, a statement of the objectives and scope of activities to be undertaken, the performance criteria by which the authority might be assessed, and any other information the Treasurer directed (ACT *Financial Management Act 1996*:S58).

In addition to considerable freedom to undertake a range of day-to-day activities, the autonomous role given to TCH and ACTCC allowed relationships to occur that did not exist during the pre-PPM period. There was a direct relationship between the CEOs of TCH and ACTCC and Treasury as part of the ownership role of the Treasurer. In addition, the CEOs of TCH and ACTCC met with the Health Minister on a weekly basis. Under this arrangement the CEO of DHCC was only invited to attend these meetings every second week (interview comment: Health Minister). DHCC was especially concerned about the impact of this arrangement and saw it as giving government providers an opportunity to in effect “capture” the Health Minister and attempt to overturn provisions of the purchase agreements with DHCC and to seek more money (interview comment: senior executive DHCC).

PROVIDER CONTESTABILITY

Policy Goal

To ensure that the Government and the community obtained value for money, policy implementation arrangements associated with the PPM were designed to allow providers, wherever possible, to operate in a contestable marketplace (ACT Chief Minister’s Department 1995a:3).

Nature of Arrangements

As noted in Chapter 3, in regard to the provision of hospital services prior to the use of the PPM, DHCC pursued a policy of role specialisation, referred to as role delineation, in which TCH and Calvary had somewhat defined roles. There was some limited contracting out of hospital services during the PPM

period (see Chapter 6). However, the policy of role delineation continued during the period of the PPM. No evidence could be found of any formal arrangements to provide TCH or Calvary with an ongoing contestable role in regard to the provision of hospital services.

In contrast to hospital providers, both ACTCC and non-government providers of community services (including community care and mental health) were given a more contestable role. However, the ACT Government identified a number of situations where contestability should not apply, namely, where:

- there is a Ministerial direction;
- the market is of insufficient size to warrant a number of providers;
- the nature of the service requires government to place it in particular locations across the Territory;
- there could be adverse consumer impact such as the loss of continuity of service;
- the transaction or opportunity costs outweigh any advantages; or
- there would be a demonstrable loss in changing from the particular ethos or philosophy which is the characteristic of existing providers (ACT Government 1998d:8-9).

In the area of mental health, the PPM was implemented when:

- the ACT Government was moving 'the focus of mental heath services increasingly towards community-based support and intervention' (ACT Government 1996e:1); and
- a lack of a strong private sector providing mental health services meant that the ACT public sector was providing services which, in most States and Territories, would be provided by the private sector (ACT Government 1996d:9).

Consequently, rather than being required to provide services in a contestable environment, the role of providers of public mental health services was to 'concentrate on providing more effective services under a purchaser/provider agreement' (ACT Government 1996e:1), and to work cooperatively to achieve DHCC service goals (ACT Government 1996c:5; ACT Government 1996f:63).

Impact of Arrangements

In the health sector the extent to which providers, and especially government providers, adopted a competitive role tended to vary between providers of hospital, community care, and mental health services. There were major

differences between the providers of hospital services and the provision of community care and mental health services.

Hospital Services

The introduction of the PPM did not result in hospital service providers facing a formal competitive environment on an ongoing basis. The retention of the policy of "role delineation" meant that TCH and Calvary did not have to undertake a competitive role.

The decision to retain the policy of role delineation had considerable support from clinical staff (interview comment: CEO TCH). Moreover, it appeared that DHCC had little interest in replacing the policy of role delineation with a competitive role for hospital providers. The reasons for this were reflected in the final draft of the discussion paper titled *Acute Health Services Plan: Putting Partnerships into Practice* (DHHCC 2001) which was referred to earlier. In summary, it was indicated that in the ACT context, role delineation was needed because:

- cooperation and partnerships were essential to meet current and future demand for acute and extended care services;
- reduced hospital bed demand (as length of stay declined as a result of the growth in same day treatment) was having an impact on hospital infrastructure needs in the ACT so changes need to be planned on a territory wide basis;
- the need to maintain critical mass, and to maximize the distribution of workload and staff to meet demand was best achieved by the networking of key specialties across hospital campuses; and
- the need to manage geographic access to ensure that best patient outcomes are achieved in the light of the relatively low level of ACT demand, the high cost of providing services and the difficulties in recruiting the required expertise (DHHCC 2001:20-23).

Moreover, it was further argued that in the ACT:

> Role delineation will provide certainty for health service staff and hospital management, reduce inappropriate duplication between facilities and ensure that service planning, workforce planning and investment in capital infrastructure, and post-acute care can proceed in an orderly, sustained and strategic way (DHHCC 2001:24).

Community Care and Mental Health Services

The overall impact of the PPM on the provision of community care and mental health services was that ACTMHS and Calvary were exempted from

undertaking a formal competitive role, and ACTCC had a limited competitive role, whereas non-government providers other than Calvary were often required to compete for services provided with “new-money” (funds available for additional services).

ACTMHS and Calvary

Because of the different nature of the services provided by ACTMHS and Calvary (referred to in Chapter 3), ACTMHS and Calvary were not expected to undertake a competitive role for the provision of mental health services as part of the PPM. However, they were expected to undertake a cooperative role as part of a limited form of role delineation (ACT Government 1996c:5; ACT Government 1996f:63). Despite this, a non-government provider with considerable experience in the mental health sector suggested that ACTMHS and Calvary did not communicate very effectively in the early years of the PPM period (interview comment).

The potential for competition appeared to have in part influenced the way ACTMHS approached its relationship with Calvary, especially during the first four years of the PPM. A person in a senior management position in Calvary saw the PPM setting up barriers to cooperation. It was argued that the big problem with the PPM was that it was based on competition, and in that environment ‘people don’t cooperate.’ It was claimed that during the early years of the PPM, there was little interaction between Calvary and ACTMHS. Moreover, Calvary was not allowed to be involved with the crisis and assessment teams that formed part of ACTMHS. It was argued that, in effect, this meant that Calvary was isolated from the rest of the mental health services in the ACT, and that the lack of cooperation and communication disadvantaged clients because there was no sharing of information, services or resources (interview comment).

While the potential for competition contributed to the poor relations between Calvary and TCH, it was also suggested that during the early stages of the PPM period ACTMHS did not understand what Calvary did. The view was also expressed that Calvary’s mental health services had a bad reputation at that

time, and was seen as a “holiday home”. Moreover, there was friction between psychiatrists at both organisations (interview comment: senior manager Calvary).

Attempts to contact the director of ACTMHS during the period of the PPM to discuss the reasons for the lack of communication and cooperation between ACTMHS and Calvary were unsuccessful. However, the lack of cooperation between ACTMHS and Calvary appeared to remain largely unchanged until mid-2000, when a group comprising the chief executives and senior management of DHCC, TCH and Calvary was formed to examine and progress key mental health issues such as role delineation, funding and service gaps (ACT Government 2001a:16). In terms of role delineation, a document was prepared which set out responsibilities covering community and bed-based activities related to 10 different conditions, and links were formalised between Calvary and the Belconnen mental health team (interview comment: senior manager Calvary).

ACTCC

While the implementation of the PPM had the potential to provide a competitive role for ACTCC, in reality, DHCC appeared to pursue a modified form of its role delineation policy in regard to the services sought from ACTCC. When the PPM was implemented, it was suggested by DHCC that the role of ACTCC was to implement a program structure that reflected its client base and identified priorities/business, and to maintain professional roles and career progression (ACT Government 1996d:41). Indeed, the CEO of ACTCC suggested that it was not the role of ACTCC to compete for activities in areas that are regarded as non-core business (interview comment). Consequently, while ACTCC competed to supply its core services to the Commonwealth Department of Veteran Affairs, it undertook a very limited competitive role in relation to services purchased by DHCC (interview comment: CEO ACTCC): an issue discussed in further detail in Chapter 6.

Non-Government Providers (other than Calvary)

The impact of the PPM was to provide a more competitive environment and role for non-government providers (other than Calvary) who sought to supply

services that were purchased by DHCC with “new-money” (an issue discussed in more detail in Chapter 6). Under the PPM many of the services purchased with new-money were purchased by tender. The use of tendering was a new approach, as prior to the introduction of the PPM, submission-based-funding arrangements existed (ACTCOSS 1996:11).

When the PPM was introduced the use of tendering had limited impact on the role of non-government providers. However, it appeared to be seen as having the potential for much wider use under the PPM. The introduction of tendering was seen by non-government providers as a particularly backward approach, destroying relationships and what was a cooperative and collegiate approach by non-government providers in the period prior to the introduction of the PPM (interview comment: two non-government providers with lengthy experience).

Tendering was not completely abolished during the PPM. However, in response to non-government provider concerns, DHCC modified its approach to purchasing arrangements with non-government providers, placing greater emphasis in pursuing a policy of cooperation and partnerships in regard to service provision (ACT Government 1998a:23). However, even though relationships between providers appeared to improve during the latter part of the PPM period (interview comment non-government provider), some of the distrust that followed the introduction of tendering arrangements appeared to linger.

The CEO of a major non-government provider organisation claimed in June 2002 that there was still a lack of cooperation and information sharing between non-government organisations because each organisation tried to protect its own money. Furthermore, he noted that his organisation was still unwilling to share information with others, especially where it considered its management practices were better than its competitors. On the other hand, another representative of a significant non-government organisation interviewed in May 2002 did not see competition as affecting cooperation. However, he did state that while the organisation would cooperate with

others once the tender process was over, they may not want to talk to competitors in the lead up to tenders (interview comments).

Overall, in terms of the configuration of role and role relationships which form part of the administrative architecture for the implementation of public policy, the major issue was summed up in the views of a health consultant who argued that the real policy question was, is the competitive model most appropriate for a sector that has to work on a cooperative basis? (interview comment**)**.

ENHANCED CONSUMER ROLE

Policy Goal

One of the major aims of the PPM was to enhance the role of consumers/customers in line with the concept of "consumer sovereignty" (SCFPA 1999:2). In moving that the ACT *Financial Management Bill 1996* be agreed to in principle, the then-ACT Chief Minister stated that:

> The reforms will ensure that the customer, rather than the provider, evaluates the service (ACT Legislative Assembly 1996b:1037).

Moreover, DHCC stated 'We put our customers in the centre of all we do' (ACT Government 1997b:22).

Nature of Arrangements

Arrangements to provide an enhanced role for consumers under the PPM involved DHCC:

- operating at arms-length from providers through contractual arrangements (interview comment: senior executive DHCC);
- involving bodies such as the Health Care Consumers Association ACT Inc. on planning and other committees and as part of community consultation on service reforms (ACT Government 1998d:7); and
- setting up groups such as the Diabetes Council, and the Cancer Council, to give consumers and stake-holders a say in service development (interview comment: senior executive DHCC).

In addition, in purchase agreements with government providers and Calvary, DHCC was committed to:

- extending the information base on which future planning and funding decisions were to be made by, inter alia, involving the community in decisions about resource allocations; and

- developing purchase plans that demonstrated a consumer focus, and inter alia, would
  - encourage community involvement in the decision making processes associated with the purchasing and provision of health and community care services; and
  - monitor outcome related performance indicators of patient care satisfaction (ACT Government 1996c:v&vi).

In contrast to contracts with government providers and Calvary, there were no direct requirements in non-government provider contracts related to consumers. However, in the standard contract between non-government providers and DHCC, non-government providers were to supply services 'having regard to progressing the broad policy goals of' the program under which they were funded.' For example, for those providers funded under the Home and Community Care (HACC) program, one of the objectives of that program was:

> to provide flexible, timely services that respond to the needs of consumers (Commonwealth Department of Health and Aged Care 2000:9).

Impact of Arrangements

The impact of arrangements taken to provide consumers with an enhanced role varied between DHCC, government providers and Calvary, and non-government providers (other than Calvary).

DHCC

The impact of the PPM was that DHCC had difficulty in matching its actions to its rhetoric about the role that consumers would play. Furthermore, DHCC had to rely more on providers than was the intention under the PPM.

As was noted on the previous page, the approach taken by DHCC was underpinned by rhetoric which referred to consumer sovereignty, and put customers in the centre of all that DHCC did. Such rhetoric built up expectations that DHCC was always going to find very difficult to meet. Therefore it is not surprising that it was claimed, in a report on the implementation of service provision arrangements in the ACT, that in the approach taken by the ACT Government as part of the PPM, there was not much to indicate that the goal of consumer sovereignty was any more than a

cliché, rather than a reality (SCFPA 1999:2). Furthermore, the extent to which the NPM approach enhanced the role of consumers in the health sector was questioned. There was a concern by the Health Care Consumers Association ACT Inc. that the ACT Government's rhetoric did not match its actions in terms of meeting the needs of consumers (interview comment). Also, in the early stages of the PPM, there was concern in some areas of the ACT health sector 'about whether we really want consumers "buggering up" our decision making' (Butt 1998:3).

As previously mentioned, the use of the PPM was expected to result in a much reduced role for providers, as DHCC undertook a proxy consumer role. However, a feature of the use of the PPM was the significant role that providers played in relation to the policies DHCC used to enhance the role of consumers (a matter dealt with in greater detail below). A senior executive of DHCC noted that while it had independent means of getting consumer input (to implement the policy of providing an enhanced role for consumers), it also needed the expertise of providers (interview comment). In this regard, as illustrated below, DHCC appeared to have substantially devolved to providers the responsibility for providing consumers with an enhanced role, through purchase agreement arrangements. A major reason for this was that under the PPM approach DHCC had limited face-to-face contact with consumers of health services (Rosenberg 2000:50). Moreover, it was suggested that providers are more organised than consumers and have more opportunities to comment (interview comment: health consultant).

Government Providers and Calvary

The implementation of the PPM resulted in government providers being actively used as part of DHCC's goal of providing an enhanced role for consumers through purchase agreement arrangements. There were provisions in purchase agreements for providers to involve consumers in activities that would enhance their role, and to undertake consumer satisfaction surveys.

Involving Consumers

During the PPM period, providers made some progress in developing arrangements that enhanced the role of consumers. For example, in 1997 TCH reported that it had developed a strategic plan for customer-driven change management, adopted ACT Public Service Customer Service Standards, and participated in three DHCC-sponsored focus groups on Women's and Children's Health, Medical Services and Surgical Services (ACT Government 1997d:200-201). However, overall the progress made by the major providers appeared to be slow. For example, it was 2001 before TCH reported that there was customer representation on the Hospital's Patient Care and Quality Improvement Committee, Clinical Health Improvement Steering Committee, Clinical Ethics Committee, Patient Education Group, the Survey Resource Group, and a number of working groups (ACT Government 2001e:96). Furthermore, even in 2001 there were a number of consumer involvement issues that were outstanding. For example, the following consumer involvement issues were included in the TCH strategic plan for 2001-2004:

- the identification of relevant committees requiring consumer representation and the invitation of consumer representation by 2002;
- the establishment of a Consumer Advisory Forum by July 2002; and
- the development of a Consumer Participation Policy and Consumer Participation Strategy by September 2002 (Canberra Hospital 2001c:5).

The provision of community care services by ACTCC was another area where progress in providing an enhanced role for consumers was slow. For example, even in the purchase agreements for 2000-01 and 2001-02 it was stated that:

> to ensure consumer input into service planning and provision, at least 25 percent of the relevant ACT Community Care committees will have a minimum of one consumer representative (ACT Government 2000c:3; ACT Government 2001h:3).

During an interview in March 2001, a senior executive of ACTCC advised that there were consumers on a number of committees including the quality committee and that the aim was to get consumer input on implementation issues (interview comment). However, in March 2002, the CEO of Health Care Consumers Association ACT Inc. suggested the relationship of that

organisation with ACTCC was only in its infancy, with ACTCC just starting to take consumers and the Association more seriously.

Consumer Surveys

TCH, ACTCC and Calvary all undertook consumer surveys. In particular, TCH and Calvary undertook surveys using an instrument developed initially by Parkside, a firm with international experience with such surveys. The hospitals appeared to take the results of the survey seriously. In 2000, TCH reported that the results of the survey had been analysed, and service improvements implemented across the hospital (ACT Government 2000a:11). However, during interviews the person responsible for managing the survey was concerned that despite the substantial amount of data collected by the hospital from the survey and other sources, which was reported to DHCC, the information appeared to have little impact on the activity of the purchaser (interview comment), a view supported by a representative of Health Care Consumers Association ACT Inc. (interview comment). Moreover, despite the fact that the consumer surveys undertaken were based on an instrument developed by a group that specialises in consumer research, one of the consumer organisation representatives suggested that the surveys didn't ask the right questions (or ask questions in the right way), were biased in favour of people on higher incomes, and asked at a time when respondents were somewhat vulnerable (interview comment).

Non-Government Providers (other than Calvary)

Non-government providers often undertook a combined provider/advocacy role and during the PPM there appeared to be virtually no change. During interviews several representatives of non-government provider organisations spoke of the contribution such organisations made in enhancing the role of consumers through their advocacy activities. As an example, a representative of a well established non-government organisation claimed that in many instances it was a community group or non-government organisation in its advocacy role, and not the government that identified consumer need and then sought funding for it. Furthermore, it was claimed that in other instances non-government organisations were often created as

the result of an identified community need. Then what often happened was that, as a result of societal concerns, the government resourced the activities of these organisations. Therefore, it was argued that it was inappropriate for the government to try to play the role of the community in this area (interview comment). However, a senior DHCC executive involved with community care issues claimed that non-government providers often have problems in resolving their advocacy and provider roles (interview comment).

SUMMARY

This Chapter provides data related to role and role relationship issues that were associated with the administrative architecture the PPM was designed to develop. It identifies a number of problems that illustrate the crucial part that the administrative architecture plays in the implementation of public policy, in this case, the need to give adequate attention to the configuration of role and role relationships through which public policy is implemented. It focuses on issues related to:

- role separation arrangements;
- giving government providers greater autonomy;
- the provision of a more contestable role for providers; and
- enhancing the role of consumers.

The new role separation arrangements confused rather than clarified roles and relationships. Furthermore, the separation of ownership and purchasing roles was seen as unnecessary by DHCC. The separation arrangements ignored the role of a line minister and resulted in conflict between Treasury and DHCC over operational issues.

The separation of ownership and purchasing roles across DHCC and Treasury failed to take account of the responsibility of a line department. Also it was an arrangement that was seen as unnecessary by, and lacked support from DHCC. In fact it was seen as having the potential to undermine the role of DHCC rather than clarifying ownership and purchasing roles. Arrangements for the separation of the role of DHCC as purchaser and ACTHCCS as provider, through naivety in legislation drafting, gave

ACTHCCS a role that potentially overlapped with DHCC. The consequence was tension and conflict between them.

The autonomy given to government providers allowed them to develop relationships with the Treasury and the Health Minister that resulted in tension between DHCC and government providers. The relationships that developed were seen by DHCC as giving government providers the opportunity to engage in “capture” and undermine the contractual arrangements they had with DHCC.

While it could be expected that the PPM would result in providers undertaking a more contestable role, DHCC largely pursued a policy of role specialisation (referred to as role delineation) for government providers and Calvary. Competition was largely confined to non-government providers of community care and mental health services who tendered for services purchased with new-money. However, non-government providers saw such a competitive role as undermining provider cooperation.

Finally, the PPM was supposed to provide an enhanced role for consumers, and limit opportunities for provider capture. However, Government and DHCC rhetoric built up expectations that were not matched by action. Moreover, PPM arrangements often distanced DHCC from providers, resulting in providers, and especially government providers, playing a significant part in implementing policies designed to enhance the role of consumers. In the next Chapter data is provided that relates to issues associated with the resource allocation arrangements that form part of the administrative architecture.

Chapter 6

Resource Allocation

This is the second of three Chapters providing empirical data to support the thesis argument that the administrative architecture through which public policy is implemented plays a crucial part in the implementation of that policy. This Chapter provides data related to issues associated with resource allocation arrangements that were part of the PPM approach and consequently part of the administrative architecture it was designed to develop. The detailed analysis of the data in Chapters 5, 6 and 7 and related comment in the Literature Review (Chapter 2), is in Chapter 8. In particular, this Chapter provides data on:

- Purchase requirements
  - in terms of outputs; and
  - in contractual documents;
- Service purchasing arrangements that
  - focus on consumer needs; and
  - are at contestable prices.

In addressing each of these issues, the Chapter provides an overview of the policy goals, the nature of the arrangements (the means and instruments used to achieve these goals), and the impact of arrangements during the implementation process (the impact of the policy goals and means and instruments used).

In brief, the data show that:

- specifying and costing services in terms of outputs was not as beneficial as expected;
- inexperience, demand uncertainty, resource constraints, lack of robust cost data, and timing issues made it difficult to clearly specify and cost purchase requirements in contracts;
- focusing on the needs of consumers was made difficult because of inherent problems in both determining and meeting the needs of consumers; and
- in implementing contestable purchasing arrangements only limited use was made of competition because of conflicting objectives, and benchmarking presented problems because of the atypical nature of the ACT.

PURCHASE REQUIREMENTS AS OUTPUTS

Policy Goals

Under the PPM, the aims of expressing service requirements as outputs in the health area in the ACT were to improve performance by shifting the emphasis from a focus on inputs to a focus on outputs and outcomes, and to ensure that only outputs necessary to the government's desired outcomes were purchased (ACT Chief Minister's Department 1995b:5; ACT Government 1996c:i).

Nature of Arrangements

When the PPM was introduced, at an ACT Budget level, program budgeting was replaced with funding by outputs and output class. As noted in Chapter 3, there was a Budget Output Class "Payments for Services Purchased." From 1997-98 onwards, within this Budget Class there were sub-classes that included hospital related services, community care services, and mental health services. Details of the quantity of major outputs purchased were shown in terms such as "number of occasions of service" together with the total cost in terms of cost per "1000 head of population." There was no single system of classifying and pricing health related outputs in purchase agreements during the period of the PPM. Hospital outputs were predominantly classified by service type with outputs for acute inpatient services related to Diagnosis Related Groups (DRG) (See Table 6.1). Community Care services provided by ACTCC were classified by program type such as the "Alcohol and Drug Program".

Mental health services purchased from ACTMHS and Calvary were classified under broad output categories. The categories used for:

- ACTMHS services were inpatient services, outpatient services, community and extended care, and national mental health strategy funding;
- Calvary services were inpatient and outpatient services, except in the last year of the study, when outpatient services were included with some other services in the category community and extended care services.

Table 6.1

FUNDING BASIS OF OUTPUTS BY OUTPUT AREA AND OUTPUT TYPE (a)

Output Area	Output Type	Output Pricing Basis
Inpatient	Acute Services: Cardiology, Cardiothoracic, Dental, Endocrinology, ENT, Gastroenterology. General Medicine, General Surgery, Gynecology, Hematology, Neonatology, Nephrology, Neurology, Neurosurgery, Obstetrics, Oncology/Radiotherapy, Ophthalmology, Orthopedics, Pediatrics, Plastics, Psychiatry, Rehabilitation, Respiratory, Rhunatology, Urology, Vascular (b)	Cost Weighted Separations (c)
	Critical care	Occupied Bed Days
	Nursing Home	Occupied Bed Days
	Renal Maintenance Dialysis	Dialysis Episode, & Number of Continuous Ambulatory Peritoneal Dialysis patients
	Long stay outliers	Occupied Bed Days
Non-Inpatient	Emergency Department	Cost Weighted Occasions of Service (d) or presentations in 2001-02.
	Outpatient: Medical, Surgical, Obstetrics & Gynecology, Pediatrics, Psychiatry, Radiology, Radiotherapy, Wound Clinic, and Group Services	Cost Weighted Occasions of Service (d) (In 2000-01 & 2001-02 they were block funded)
	Pathology	Grant funded
Other	Other	Grant funded

Notes: (a) This table has been constructed to illustrate the main outputs types used. It is not designed to fully reflect the treatment of all outputs during the PPM. For example, allied health activities, which were transferred to ACTCC during the period of the PPM, have been excluded.

(b) In 2001-2002 these 26 output types referred to as acute inpatient services were consolidated into 15 ACT Patient groups.

(c) Related to the DRG classification system.

(d) Based on a weighted casemix classification system developed in South Australia.

Source: Purchase Agreements between DHCC and TCH, and Statements of Intent between the Treasurer and CEO of TCH.

Outputs purchased from non-government providers of community care and mental health were identified in contracts in terms of the services they provided. However, in annual reports of DHCC the outputs supplied by non-government providers were not identified, but the funding that providers received was identified by program.

Impact of Arrangements

The specification of service requirements in terms of outputs was seen as providing a clear idea of what the Government was buying (interview comment: senior executive DHCC). However, in regard to the impact of PPM arrangements there were issues associated with the:

- costing of outputs using DRG;
- specification of outputs in a program framework; and
- specification of outputs from non-government providers.

Costing of Outputs using DRG

The use of DRG as a system to classify and price hospital outputs was seen as offering considerable benefits as a funding tool by providing a basis for paying hospitals for the cost and complexity of the patients treated. The system was also seen as intrinsic to the move to output funding (ACT Government 1996b:7). However, the use of DRG was not without problems. There was considerable opposition to the use of the system by the medical profession, and there were difficulties in applying the system to the ACT.

Medical Profession Opposition

There appeared to be considerable opposition to the use of DRG and output funding from the medical profession. The first CEO of DHCC suggested that the concern and antagonism to casemix by ACT doctors was based on experience in Victoria where casemix was used to reduce funding (interview comment). However, while only a small number of clinical staff was interviewed, they appeared to be concerned about a number of issues other than reduced funding. There were concerns that:

- DRG were not very practical, and were easy to fudge (senior specialist);
- the approach of DHCC to the use of DRG was part of the obsession with process by its CEO and by senior administrative staff of DHCC, who were seen as being totally ignorant of the business of the hospital (senior doctor TCH);
- from a clinical perspective the output funding model in the ACT was of limited meaning at the bedside, and was remote from the realities of clinical practice in Canberra (another senior doctor TCH); and
- output funding was a production line approach, when the unit of care is the patient (nurse in a senior administrative position).

The most detailed evaluation of the limitations of DRG was provided by a senior doctor who had undertaken considerable research on DRG and had prepared papers on this issue. He suggested that DRG were developed as a language that allowed doctors to communicate with one another about clinical issues and argued that its use as a system of recording costs for episodes of care was artificial. Moreover, because DRG were based around episodes of care and not patients as such, they were seen as creating incentives to increase the number of episodes of care (interview comment). In papers he helped to prepare related to the ACT situation, it was noted that the use of DRG was a system where the price per individual DRG was based on the average costs for a number of hospitals in Australia, and not just hospitals in the ACT (Canberra Hospital 2001a:14). Furthermore, it was argued that:

- differences between the structure of the ACT hospital system and those in the states influenced how episodes of care were reported and costed (Canberra Hospital 2001a:14); and
- casemix funding models such as those using DRG required a critical mass within each DRG class, and this did not occur in the ACT (Canberra Hospital 2001b:25).

Limitations in the ACT

A senior executive from TCH suggested that while a casemix type approach such as the use of DRG was not a bad way to fund hospitals in a big system, it had limitations in a small system such as the ACT (interview comment). The major impact of these limitations was that in costing inpatient services purchased by DHCC from TCH and Calvary through purchase agreements, DRG were only used to determine what was referred to as “benchmark prices”. Total payments to TCH and Calvary in purchase agreements were supplemented with additional block funding. This additional funding was seen as necessary to cover what was referred to in purchase agreements as “ACT cost factors”. Funding for these factors was expected to cover items such as a lack of scale economies, a lack of access to community-type inpatient services, higher levels of service and responsiveness, higher superannuation costs, and inefficiencies associated with the delivery of services (ACT Government 2002a:10-11).

A senior executive in DHCC said that the inclusion of ACT cost factors was part of the "softly, softly" approach to the introduction of DRG (interview comment). However, this additional funding for ACT public hospitals was often quite considerable (See Table 6.2). This made the use of DRG as a basis for funding acute care outputs on the basis of cost weighted separations (as shown in Table 6.1) somewhat meaningless during the PPM period.

Table 6.2

BENCHMARK AND ADDITIONAL FUNDING FOR THE PURCHASE OF INPATIENT SERVICES: BY HOSPITAL AND FUNDING TYPE: 1996-97 TO 2001-2002

$ Million

Year	**TCH**		**Calvary**	
	Benchmark	Additional	Benchmark	Additional
1996-97	99.0	27.6	26.7	2.5
1997-98	102.5	30.0	32.0	1.0
1998-99	110.1	24.4	32.3	1.9
1999-00	119.9	17.9	34.0	1.5
2000-01	100.6	5.7	25.4	5.0
2001-02	106.8	13.0	27.3	10.2

Source: Purchase Agreements between DHCC and, TCH and Calvary 1996-97 to 2001-2002.

Output Specification within a Program Framework

As noted earlier, under the PPM approach the use of output funding was expected to replace program funding. However, a feature of resource allocation arrangements under the PPM was that outputs were often specified within a program framework. This occurred in resource allocation arrangements related to: the ACT Budget, purchase agreements between DHCC and ACTCC, and the funding provided to non-government providers of community care and mental health services.

In the ACT Budget the resources allocated to output sub-classes such as hospital, community care, and mental health services were expressed as a single cost figure, related to the cost/price of all outputs for that sub-class. No further break down of costs was provided. In discussion with representatives of Treasury, DHCC and TCH it was clear that this occurred because the resources allocated to a sub-class largely represented the expenditure last

year plus an allowance for inflation and new initiatives (interview comment). The cost figure was not based on an estimate of the aggregate cost of the outputs to be purchased.

In the period prior to the introduction of the PPM a program structure was used to allocate resources to the community division of DHCC (whose activities were largely taken over by ACTCC). When the PPM was implemented, the outputs purchased from ACTCC were classified both in the ACT Budget and in purchase agreements between DHCC and TCH within a program structure. Consequently, the funding that ACTCC received for the services it supplied was not directly related to types of outputs.

The use of program arrangements to specify output expenditure meant that it was not possible to know how much the ACT government spent on purchasing outputs such as respite care, the cost of which was not only not separately shown, but also funded by a number of different programs. As an interviewee from ACTCC noted, under the program related classification system used it was not uncommon for providers to have to get funds from more than one program to meet client needs. However, there appeared to be support for the program approach by senior executives at ACTCC. A senior executive at ACTCC expressed the view that programs provided greater flexibility than defining outputs. Also the CEO of ACTCC suggested that the use of programs was a very useful approach when seeking Government funding (interview comments).

Output Specification: Non-Government Providers

Under the PPM arrangements the outputs purchased by DHCC from non-government providers were often specified in terms of activities, and somewhat artificially priced. For example, the outputs specified for one provider of community care services were:

1. The conduct of weekly social groups providing relevant meaningful social support activities;
2. An information service providing information through a range of media; and
3. The development of support links (Extract from contract between DHCC and provider. Outputs 2 and 3 have been truncated for confidentiality reasons).

For the above provider, and many others contacted during interviews, the price paid was not directly related to the outputs purchased and was thus artificial. In the above example the price paid for outputs was in effect related to the funding of a certain staff level. Another provider, who was contracted to provide a certain number of sessions of activity, advised that the funding provided represented only about 50% of its operating costs. In fact the funding was designed to fund the employment of a set number of staff (interview comments).

Even where unit costing was used, funding arrangements appeared to be somewhat arbitrary. For example, for one provider that supplied programs and counselling, the unit cost of the services purchased was related to the "number of contacts". The funding did not cover the costs associated with the activities of volunteers. For another provider who supplied educational, information and referral services, the unit cost of the services purchased was related to "occasions of service," where an occasion of service was described as an appointment, visit and incoming phone call with the person seeking information. Outgoing calls were excluded (interview comments).

In the report by Rogan et al. (1997:58-60) related to service purchasing arrangements in the ACT, it was noted that the costing of non-government services was difficult because little work had been done on what it cost non-government organisations to deliver services to a specified quality. It was also noted that governments were reluctant to move away from a "contribution" model of funding non-government services because of the pressure it put on costs. In this context one non-government provider expressed the view that 'the Government doesn't pay the full cost of the services from non-government providers: they want to buy a car, but only want to pay for the wheels and the front seat' (interview comment).

PURCHASE REQUIREMENTS IN CONTRACTS

In implementing the PPM, the two main types of contractual relationships for the specification of purchase requirements were those between the Minister

and DHCC, and those between DHCC and providers. These contracts were often referred to as purchase agreements.

Contracts between the Minister and DHCC

The goal of specifying purchase requirements in a contract between the Minister and DHCC was to specify 'the substance of the outputs sought, in greater detail than in the Budget Estimates document' (ACT Chief Minister's Department 1996:21). The means of achieving this goal was to be through the use of an annual purchase agreement between the Minister and the CEO of DHCC. This agreement (which was entered into at the time of the delivery of the ACT Budget) identified the outputs and deliverables that DHCC was expected to provide. While this document was supposed to expand on the output information provided in the annual ACT Budget, an examination of the purchase agreements showed that in reality there was the same amount of detail on outputs in the purchase agreement as there was in ACT Budget papers. A senior executive in DHCC argued that because the purchase agreement duplicated the output information in the ACT Budget papers, it served no useful purpose (interview comment).

Contracts between DHCC and Providers

Policy Goals

The policy goal of specifying purchase requirements in contracts between DHCC and providers was to specify in some detail the outputs that needed to be supplied by the provider to meet the requirements of the purchaser, and the policy goals of the government (ACT Chief Minister's Department 1995a:7; ACT Chief Minister's Department 1996:8; Weeks & Anderson 1995:41).

Nature of Arrangements

Under the PPM, purchase requirements were set out in contracts that were negotiated between DHCC and providers. DHCC had far more substantial purchase contracts with the larger providers (TCH, Calvary and ACTCC) than with non-government providers other than Calvary. The contracts with the larger providers were annual contracts that were similar in structure,

containing schedules that included pricing specifications. However, contracts with these larger providers were not negotiated and finalised until the ACT Budget was brought down. Mental health requirements were included in the contracts of TCH and Calvary, and especially in the final years of the PPM, were funded in accordance with the requirements of national agreements (ACT Government 2002a:17).

In contrast to the larger providers, for much of the PPM period, there was a standard contract between DHCC and non-government providers of both community care and mental health services. The contract included six schedules (See Appendix E). Schedules 2 and 4 related directly to service purchasing arrangements. Schedule 2 included the services required and related outcomes, outputs, performance requirements and quality standards. There was a component for each separate service required. For example, the contract of one of the providers interviewed contained Schedules 2A, 2B, 2C and 2D. On the other hand, Schedule 4 was where the purchase price, payment details, financial requirements and financial reporting arrangements were set out. The length of these contracts varied from one to three years.

Impact of Arrangements

A senior executive of DHCC suggested that with the introduction of the PPM the risk associated with purchasing moved to the purchaser. Therefore, the purchaser needed to get requirements correct (interview comment). However, ensuring hospital requirements were correct was a problem that persisted during the PPM period. It was exacerbated by the fact that when the PPM was first introduced, DHCC staff did not have a clear perception of purchase requirements or their cost.

The Hospital Sector

In the hospital sector in the ACT the process of negotiating contracts was affected by:

- accounting system deficiencies; and
- changes in the timing of the ACT Budget.

During interviews attention was drawn to the lack of an accounting system in place that enabled the accurate cost of providing services to be determined (interview comments: Senior executives of DHCC). Furthermore, an analysis of purchase agreements showed that in the first year of the PPM (1996-97) the annual purchase agreements DHCC had with TCH, and Calvary, were signed at the same time as the ACT Budget was brought down (September 1996), almost three months after the start of the contract year. However in 1997-98 onwards the ACT Budget was brought down earlier (May in most years) see Table 6.2. In 2001-02 the ACT Budget was brought down in May 2001 but the purchase agreement between DHCC and TCH was not finalised until 10 May 2002.

The reason for the delay in finalising the contract was followed up during interviews. A director in an operations area in TCH gave the following description of the contracting process as it applied to TCH in the latter part of the PPM period. He stated that in the early stages of the ACT Budget formation process, TCH would provide details of its targets for the year and the new initiatives it would like to see. This information was given to DHCC in the December/January period. DHCC then sought money in the Budget in May. Then in June, DHCC would come back to the TCH to commence negotiations about the Purchase Agreement. This director and the Chairman of Board both suggested that the timing of the negotiation process, and lack of agreement about price and volume issues, contributed to delays in regard to the finalisation of purchase agreements between DHCC and TCH (interview comments). The date when the purchase agreement between DHCC and Calvary for 2001-02 was not shown on the copy obtained during the research. However in January 2002, the CEO of Calvary stated that the purchase agreement had gone to the national board of the Little Sisters of Mercy hospitals for approval before being finalised (interview comments).

Table 6.3

DIFFERENCES IN TIMING: BUDGET AND PURCHASE AGREEMENT SIGNING DATES: TCH, CALVARY, AND ACTCC

Year	Budget Date	Date Purchase Agreement Signed		
		TCH	Calvary	ACTCC
1996-97	24 September 1996	23 September 1996	23 September 1996	23 September 1996
1997-98	6 May 1997	28 May 1997	Not shown (a)	21 May 1997
1998-99	23 June 1998	17 July 1998	Not shown (a)	13 July 1988
1999-00	4 May 1999	20 August 1999	4 June 1999	28 June 1999
2000-01	23 May 2000	10 October 2001	11 October 2000	25 September 2000
2001-02	1 May 2001	May 2002	Not shown (a)	29 October 2001

Note (a) the date the agreement was signed was not shown on the copies obtained. However, when interviewed in January 2002, the CEO of Calvary noted that the 2001-02 purchase agreement had gone to the hospital's national board for approval.

Source: ACT Budget Papers, and Purchase Agreements between DHCC, and TCH Calvary and ACTCC: 1996-97 to 2001-02.

ACTCC and Non-Government Providers

Non-government providers saw the lack of experience in DHCC that followed the separation of purchasing roles and pricing issues as impacting on the process of specifying purchase requirements in contracts. A senior manager in ACTCC claimed that because there was a lack of experience in DHCC, it was ACTCC that tended to drive what would happen by stating the services they wanted to provide rather than DHCC as purchaser telling ACTCC as provider what was wanted. A senior executive in ACTCC also referred to the problems of pricing outputs (interview comments). On the other hand, non-government providers saw the lack of experience in DHCC (exacerbated by high staff turnover) as presenting problems with the specification of purchase requirements in contracts. For example, one provider was particularly concerned that in some instances DHCC staff not only did not know what they wanted but also had a poor understanding of accrual accounting. Another expressed the view that 'a lot of people in government don't understand business fundamentals' (interview comments).

FOCUSING ON CONSUMER NEEDS

Policy Goals

Focusing on consumer need was seen as an important goal of the PPM in the health area. Changes in the delivery, presentation and content of health

services were seen as being driven by consumer need for new and more customised health care services (DHCC 1996b:11&13). Furthermore, when addressing issues associated with planning, development and delivery of health and community services, a report on a 1998 review of the ACT health system *Setting the Agenda*, stated that:

> services should be focused on best meeting the needs of individuals and population groups, rather than on the needs of providers or provider organisations (Moore 1998:21).

Nature of Arrangements

There was a specialised planning unit within the Department that undertook needs analysis and analysed need, demand, and priorities with most of the results being used internally (interview comment: executive director DHCC). Information on consumer needs was also provided through the Chief Health Officer's report (interview comment: senior executive ACTCC). However, under PPM arrangements DHCC also relied on providers as well as consumers to help it both identify and meet consumer needs through purchase agreement arrangements (ACT Government 1996c:v; ACT Government 1996f:v; ACT Government 1996g:8).

In terms of meeting consumer needs, in the ACT (as elsewhere) government funding for public health services was based on what the government could afford rather than consumer needs. In this situation health services were rationed according to clinical need and urgency (Standing Committee on Health and Community Care 1999:5-9). In the period prior to and during the PPM in the ACT, rationing (especially of hospital services) was a clinical responsibility with patients being categorised and prioritised according to well established guidelines (Standing Committee on Health and Community Care 1999:10). There was also rationing of community services. For these services, DHCC generally expected ACTCC and non-government providers to manage demand for the services they were funded to supply (ACT Government 2000c:6-7, and interview comment: senior executive DHCC). Moreover, in regard to services purchased from non-government providers, DHCC appeared to see its main function as ensuring that there was equality

of access to the services provided and that people were not being treated differently (interview comment: senior executive DHCC).

Impact of Arrangements

While focusing on the needs of consumers was a goal of the PPM, there were inherent problems in determining the needs of consumers as well as meeting consumer needs.

Determining Consumer Needs

One of the impacts of the arrangements put in place under the PPM was to highlight the difficulties associated with focusing on the needs of consumers. Two areas where determining consumer needs presented particular difficulties were in the provision of mental health services, and in services provided by non-government providers other than Calvary.

Mental Health Services

The assessment of mental health consumer needs was difficult and somewhat subjective, due to a number of factors. First, many people with a mental health disorder do not regularly attend health services for mental health related problems (AIHW & CMD 2003:60). Second, during the period of the PPM the focus on mental health at both a Commonwealth and ACT level expanded from an emphasis on the needs of the 3% of the population with a serious mental illness, to a greater interest in the needs of people with a mental disorder, and mental illness prevention (Commonwealth Department of Health and Aging 2002:7). Third, because of its small size, information on the ACT was often not available from national studies (AIHW & CMD 2003:60). Information used to determine the mental health status of the ACT population was limited to a range of small surveys including National Health Surveys, Quality of Life Surveys, and the National Survey of Mental Health and Wellbeing (ACT Government 1998b:12).

Services Supplied by Non-government Providers

The diversity of services provided by non-government providers other than Calvary appeared to make the determination of the needs for services they supplied difficult. As noted earlier, especially when the PPM was first implemented, DHCC appeared to have a poor understanding of the services non-government providers supplied, and the extent to which they met consumer needs. The negotiation and reporting arrangements that followed the introduction of contractual arrangements helped to improve DHCC's understanding of consumer needs. For example, as part of the reporting process, non-government providers were asked to identify unmet need. However, there was some concern among non-government providers as to whether this information was, as one non-government provider stated, 'put to good use.'

A number of concerns were raised by non-government providers during interviews about the general approach to needs assessment by DHCC. These included concerns that:

- DHCC often lacked first hand knowledge of what providers did ;
- there was no opportunity for people to sit around and discuss unmet need, consequently under arrangements in place consumers were left out;
- the values of the purchaser were imposed on clients, resulting in a gap between what clients can have and what they need; and
- the processes for assessing individual needs were inadequate, often resulting in an organisation having to provide more resources than the referring organisation thought necessary.

Despite the concerns raised above it was obvious, from comments made during interviews, that no one considered improving needs analysis to be an easy or low cost exercise. One non-government provider suggested that 'the lack of funds made doing proper needs analysis a bit fanciful.' Moreover, there were other non-government providers that thought that DHCC was generally aware of consumer needs but lacked the resources to undertake more extensive studies. However, a representative from a large non-government provider organisation was concerned that there had been review after review but nothing had been done. Furthermore, a health consultant suggested that the process of determining need was not well developed and

that it would take some time to develop a better mechanism (interview comments).

Meeting Consumer Needs

Meeting consumer needs was often incompatible with resource allocation objectives. Two significant issues raised during interviews were the resource rationing arrangements used during the PPM period, and the conflict that occurred between the goals of meeting consumer needs and achieving value for money.

Resource Rationing Arrangements

Budget constraints meant that in meeting consumer needs resources had to be rationed. While there were well established means of rationing hospital services that predated the introduction of the PPM, this was often not the case for many other health and community care services. For services DHCC purchased from ACTCC, demand management was largely devolved to ACTCC within the framework of performance targets (ACT Government 2000c:6-7). However, concern was expressed by a senior executive of ACTCC that under this arrangement there was a lack of DHCC guidelines for developing a framework for service rationing. Such guidelines were seen as necessary because as a senior manager in DHCC suggested, the government often provided funding for say 20,000 units of a service when there was a community demand for 25,000 units (interview comments).

The lack of robust guidelines for the rationing of services under PPM arrangements was also of concern to non-government providers of community services, especially in regard to the issues of appropriateness and equity. Concerning the issue of appropriateness, it was argued by one long-standing non-government provider that the approach taken was to adopt a funding mechanism that reduced everything to a common denominator. As an example, it was suggested that the government might decide to give everyone three units of service, so even if a person needed one or five units of service, they received three.

In relation to the matter of equity, there was concern by non-government providers that arrangements under the PPM did not ensure that services were provided equitably, indeed it was suggested that there were no guidelines that adequately addressed the issue of equity. For example, it was noted that while clients were expected to contribute towards the costs of some of the services provided (such as HACC services) there was no consistent policy in regard to the charging for such services. It was largely left to individual organisations to develop their own fee arrangements (interview comments).

Value for Money

From a resource allocation perspective, under PPM arrangements the objective of meeting the needs of the consumer at times clashed with the objective of seeking value for money. During interviews, the political decision to undertake activities at TCH such as bone marrow transplants and cardiothoracic surgery were cited as major examples of decisions that met consumer needs but did not provide value for money from a resource allocation perspective. It was asserted that because of the low throughput associated with these activities, the hospital could not but undertake these activities at a high cost and without considerable excess capacity (interview comment: senior executive TCH).

CONTESTABLE PURCHASING

Policy Goal

The goal of using contestable purchasing arrangements was part of the government's desire to see that public funds were spent wisely by purchasing efficiently produced goods and services from public and private sector suppliers (ACT Government 1998d:8; Weeks & Anderson 1995:53). The two means of undertaking the goal of contestable purchasing during the PPM period were competition and benchmarking (ACT Chief Minister's Department 2000:4). Because of their different impact, the nature of arrangements and the impact of arrangements associated with the use of competition and benchmarking are considered separately below.

Competition

Nature of Arrangements

Even before the PPM was introduced, there was a degree of informal competition between providers of health and community care services (Rogan et al. 1997:47; DHHCC 2001:20). However, the main thrust of ACT government policy was to focus on arrangements that avoided duplication, to ensure a cost effective approach to service delivery (DHCC 1995:6). While the introduction of the PPM provided an opportunity for greater competition, the arrangements put in place during the PPM period were not designed to provide a significant overall increase in competition.

DHCC purchased hospital services almost exclusively from TCH and Calvary in accordance with the policy of role delineation, which was discussed earlier. However, there was one instance, in June 2000, when DHCC put substantial hospital services out to tender to reduce the waiting time for elective surgery (interview comment: Health Minister).

In contrast to hospital services, DHCC pursued a more limited version of role delineation in regard to community care and mental health services. When the PPM was implemented ACTCC took over functions from the previous community division of DHCC and continued to undertake these functions during the PPM (interview comment: senior executive ACTCC). Also DHCC relied heavily on ACTMHS and Calvary to provide mental health services and continued to purchase a range of clinical inpatient, assessment, and outpatient services for people experiencing moderate to severe mental illness under non-competitive arrangements from them. It also purchased secure care and supported accommodation from ACTMHS.

While non-government providers supplied a range of mental health and community care services, competitive arrangements were limited to a range of services purchased with “new-money” (interview comment: senior executive DHCC).

Impact of Arrangements

While the impact of arrangements under the PPM resulted in some competition between providers, there were a number of factors that limited competition. These included:

- the use of role delineation for hospital services;
- constraints on hospital tendering;
- non-government-provider resistance to tendering arrangements; and
- other limitations on competition.

Role Delineation for Hospital Services

The use of role delineation to constrain costs meant that there was no formal competition between providers of hospital services. Role delineation appeared to have been largely retained because there was a lack of support for ongoing competition between TCH and Calvary during the PPM period. There was a variety of reasons given for this lack of support:

- In the *Draft ACT Acute Services Plan* 2000, it was suggested that 'Cooperation and partnerships between providers are essential to meet the current and future demand for acute and extended care services' (DHHCC 2001:20);
- A senior Treasury executive argued that the government as owner of TCH had to ensure its excess capacity was minimised;
- A senior executive in DHCC claimed that excessive competition provides duplication and inhibits the ability to plan; and
- Another senior executive in DHCC suggested that role delineation was based on networking and suggested that 'you can't have that and competition.'

On the other hand, a senior hospital executive did not see role delineation as conflicting with competition, and claimed that role delineation was in the eye of the beholder. It was suggested that in general it was related to the capacity of what the hospital can do, noting that there were technical and clinical limits to what a hospital can do and will do (interview comment).

Constraints on Hospital Tendering

During the period of the PPM, the issues in relation to the provision of elective surgery and public hospital work being undertaken in private hospitals provided constraints on the use of tendering as a form of competition for the provision of hospital services.

Elective Surgery

In 2000 DHCC tendered out some elective surgery. The tender was open to all public and private registered hospitals in the ACT (ACT Government 2000d:4). Most of the work covered by the tender was on waiting lists to be undertaken at TCH. However, the bulk of the tender was won by Calvary.

At the time of the tender it was the general practice for public elective surgery patients to be referred by a general practitioner to a specialist, who then placed the patient on a waiting list. Because patients were not placed in a "waiting list pool", the specialist who placed the patient on the list for all intentional purposes "owned" the patient and in most cases performed the surgery (Standing Committee on Health and Community Care 1999:19-20). Therefore, the outcome of the tender meant that most patients it covered were to be either put on another doctor's operation list, or operated on by the doctor in a different hospital. This gave rise to two concerns of surgeons: taking patients off another doctor's waiting list; and requiring an operation to be done in another hospital (interview comment: senior hospital executives). Requiring an operation to be done in another hospital was seen as presenting problems because some doctors preferred to work in a particular hospital (interview comment: senior specialist). Also it was suggested that some doctors didn't want to work at Calvary, as work there was seen as too "mickey mouse" (interview comment: senior hospital executive). As a result of these concerns and the fact that the work was required to be done in three weeks, Calvary faced difficulties in getting patients to come across and eventually undertook less work than was part of the original tender (interview comment: senior executive Calvary).

Private Hospital Issues

Two of the day surgery hospitals were successful in applying for work under the tender, but the private general hospitals in the ACT did not apply. There were issues associated with private general hospitals doing public hospital work. These included concerns of health insurers about the right of private hospitals to discount services they provide to public hospitals, and the issue of how different should be the services provided to public patients in private

beds. This latter issue was seen as more of a problem for doctors than for hospitals as doctor's fees in private hospitals were often well above the standard fee (interview comment: hospital CEO). It was also suggested by a senior executive in the public system that 'specialists don't want public patients in private hospitals.' However, it was also suggested that there was not the same level of concern about this issue in day-hospitals because the work they undertook was fairly simple (interview comment). Attempts were made to discuss possible concerns of the health insurers with the representatives of the Australian Health Insurers Association. However, there was no response to requests to discuss this issue.

Non-government-Provider Resistance to Tendering

While the impact of using tenders to purchase services from non-government providers was to create greater competition for services purchased with new-money, the concept of tendering met with considerable resistance from non-government providers. Tendering was a new experience for most non-government providers.

For many interviewees, their main experience was with a tender referred to as Tender 26, which was funded by new-money in 1999-00. As part of this tender DHCC invited community-based organisations to submit tenders for innovative proposals aimed at mental illness and mental illness prevention. In advertising, the tender it was stated that:

> Priorities include decreasing stigmatising attitudes within the helping services and increasing mental health literacy in key community settings, and facilitating the development of environments that assist the emotional and social well being and which allow for diversity of needs according to life stage (Cover sheet to Tender Brief).

The tender attracted 38 applicants, many whom tendered for the first time. There were five successful tenderers of which two were new providers of mental health services to DHCC.

Tender 26 appeared to heighten concerns about, and resistance to, tender arrangements for services supplied by non-government providers. The tender proposal and pre-tender briefing was seen as vague. Some interviewees

were concerned that their tender submission was unsuccessful because they did not understand what was wanted. As one interviewee stated, there was a need for tenderers to know what the Government wanted. However, one of the successful tenderers claimed that DHCC knew what they wanted but noted that of the five successful tenders only two fully met the guidelines (interview comments).

Apart from concerns about Tender 26, there were major concerns by non-government providers that:

- the time and effort involved in tendering, took providers away from their core activities;
- organisations could employ people that were good at putting a tender together yet not have the capacity to deliver; and
- tendering for the supply of human services was not good, because there were a lot of factors on which it is hard to put a value (interview comments).

Other Limitations on Competition

There were a number of other resource allocation-related approaches that limited competition. First, as noted earlier, DHCC had a policy of limiting competition to activities that involved the use of new-money. This meant that funding for services purchased from most non-government providers was not subject to competition. Moreover, there were examples where new-money was used to purchase services on a non-competitive basis from non-government providers. These included funding provided as the result of: a service being transferred to the non-government sector from ACTMHS, a Commonwealth/ACT Agreement, or the provision of funding as the result of a submission. In some cases a long period of negotiation took place before a provider received funding as part of a submission (information obtained during interviews).

Second, the provision of mental health services was an area where as part of the ACT Government's approach to deinstitutionalisation of mental health services, the responsibility for some services was moved from the government to the non-government sector. Consequently, during the PPM period there was an increase in the proportion of non-inpatient mental health services provided by non-government providers from 5% in 1996-97 to 12% in 2001-02 (see Table 6.4).

Table 6.4

SELECTED STATISTICS ON FUNDING PROVIDED IN DHCC PURCHASE AGREEMENTS FOR MENTAL HEALTH SERVICES: 1996-97 TO 2001-02

YEAR	Funding Provided for Inpatient Services as a Percentage of Funding Provided for All Services (%)	Funding Provided to ACTMHS and Calvary for Non-Inpatient Services as a Percentage of Funding for all Non-Inpatient Services (%)	Funding Provided to NGOs as a Percentage of Funding Provided for All Services (%)
1996-97	40.28	90.84	5.01
1997-98	39.65	89.10	6.08
1998-99	43.68	86.36	7.26
1999-00	43.81	83.04	9.22
2000-01	37.12	77.42	11.49
2001-02	40.01	75.89	12.36

Source: Based on Information in Appendix Table E.1.

Third, when the PPM approach was implemented, under the arrangements put in place ACTCC took over provider functions and related programs of the former Community Division of DHCC (interview comment: senior executive ACTCC). These services were then covered in the purchase agreement it had with DHCC. They were not subject to competition. Not only were services previously undertaken by the Community Division not subject to competition but also, during interviews concern was expressed that during the PPM period, DHCC arranged for ACTCC to provide some additional services that could have been subject to competitive arrangements. One interviewee referred a contract for counselling being given directly to ACTCC when there were other non-government providers that could have contracted for the program (interview comment: health consultant).

Non-government providers were also concerned that DHCC pursued purchasing policies that favoured ACTCC. It was claimed that even when services provided by ACTCC were similar to those provided by non-government providers, ACTCC received much more funding (interview comments). Moreover, in the report of the Board of Inquiry into Disability Services in the ACT in 2002, information was provided that suggested that

accommodation places cost the Government $23,000 in the non-government sector against $72,000 from ACTCC. (Gallop 2002:105). While this difference was disputed by DHCC and ACTCC, Gallop in his findings stated:

> There is substance in the complaints that not only is there inequity in funding between government and non-government providers but that the Disability Program [a program of ACTCC] is advantaged in seeking extra funding by its proximity both to the Department and the Minister (Gallop 2002:111).

One non-government provider suggested that another reason for the difference in funding was that non-government providers were expected to operate in facilities that government providers would consider to be unacceptable (interview comment).

Benchmarking

During the PPM the main focus on benchmarking was on the overall expenditure on health services, and hospital acute care services. However, some attention was also given to the benchmarking of community health services provided by ACTCC, and non-government providers. Overall it was expected that:

- for hospital services it would be possible to benchmark ACT services with those of other States and the Northern Territory to establish what can be done to increase service efficiency and in particular to establish why per capita costs of ACT acute hospital services are so high and what can be done to increase service efficiency (ACT Government 1997a:146);
- for community health services, to achieve national benchmarking costs and to work collaboratively with community health providers to 'establish and promote best practice benchmarks, where appropriate' (ACT Government 1996b:39; ACT Government 1997c:6); and
- benchmarking would take increasing prominence to demonstrate cost effectiveness (Moore 1998:22).

Nature of Arrangements

Benchmarking Overall Health and Community Care Expenditure

In the period leading up to the PPM, and during the PPM, a widely discussed "benchmark" of overall expenditure on health and community care services in the ACT was the standardised expenditure figures for health and community care developed by the Commonwealth Grants Commission (CGC). These standardised figures were developed for each Australian State or Territory. They represent the CGC's assessment of what it would need to provide a

standard (average) service if it operated at an average level of efficiency (Commonwealth Grants Commission 1998:5). In the period leading up to the PPM and during the PPM period, standardised expenditure figures were often seen as the benchmark to which the ACT should aspire, and the difference between the actual expenditure and the standardised expenditure for the ACT was seen as an indication of overspending. In the 1995-96 Annual Report of DHCC it was noted by the CEO that the Government 'has set us the task of bringing ACT health costs into line with national averages over a three year period' (ACT Government 1996d:8).

Benchmarking Hospital and Community Service Costs

During the period of the PPM, benchmarking was largely focused on hospital activity. ACT public hospitals participated in a number of benchmarking arrangements. As a basis for benchmarking costs against other hospitals, both TCH and Calvary participated in the National Hospitals Costs Data Collection (NHCDC). This collection, which is voluntary and includes both public and private hospitals, was established to produce annual updates of DRG cost weights (AIHW 2001:245). With the introduction of the PPM, benchmark prices were set for the output types referred to earlier in Table 6.2. The DRG benchmark prices that were set for Calvary and TCH, per cost weight separation equivalence of 1, are in Table 6.5.

Table 6.5

BENCHMARK PRICES FOR ACUTE INPATIENT SERVICES (a)
A Comparison of Prices for TCH and Calvary: 1996-97 to 2001-2002 (b)

Year	TCH ($)	Calvary Public ($)
1996-97	2656	2656
1997-98	2702	2672
1998-99	2702	2576
1999-00	2702	2576
2000-01	2996	2567
2001-02	3043	2608

Notes: (a) Prices paid per cost weight separation equivalence of 1.
(b) The explanation given during interviews was that the purchase price for services obtained from THC and Calvary Public were different because the hospitals were regarded as different in nature: THC was treated as equivalent to a NSW teaching hospital.

Source: Purchase Agreements the Department of Health and Community Care had with the Canberra Hospital and Calvary Public Hospital between 1996-97 and 2001-02.

TCH was also a partner in the South East Australian Hospital Benchmarking Consortium (ACT Government 1997d:118). This was seen as enabling a comparison of casemix activity data across all hospitals within the consortium (ACT Government 1999c). Also, there was some more specific benchmarking of TCH against the John Hunter hospital in the Newcastle region (interview comment: cost centre manager TCH).

In regard to community services, as indicated above, DHCC expected that during the PPM it would work collaboratively with community service providers to develop benchmarks, and in September 2000 noted that it was working collaboratively with ACTCC to develop a unit based pricing model and that such a model was designed:

> to reflect prices based on cost analysis, benchmarking against other relevant services and/or other acceptable mechanisms (ACT Government 2000c:6).

Also, when the PPM began it was suggested in a report to the Chief Minister's Department, on service purchasing arrangements for non-government providers, that:

> work on costing services and developing an approach to pricing within service purchasing should be a priority. The Government will need to work closely with service providers in this exercise to ensure they have full information on which to begin to determine appropriate benchmarks for different service areas (Rogan et al. 1997:60).

Impact of Arrangements

Under the PPM, benchmarking increased in prominence, not because it was more widely used, but because as an instrument for comparing hospital cost it was widely challenged. There were concerns about the use of CGS figures for benchmarking, and the benchmarking of ACT public hospital costs against hospital costs elsewhere in Australia. Also, the expectation that community health care services could be benchmarked did not eventuate. These issues are considered below.

Use of CGC Figures

The use of CGC comparisons for benchmarking was questioned during the PPM period. For example, Anderson and Brennan (2000:19) noted that 'traditionally CGS data has been based on incomplete accounting data and economic measures of cost which would not pass normal accounting tests.' Furthermore it was stated, in a National Centre for Social and Economic Modelling (NATSEM) Report on *ACT Public Hospital Costs,* that CGC comparisons 'do not and are not intended to set benchmarks for assessing appropriate levels of funding for public hospital services' (Waters et al. 2001: 56).

Benchmarking ACT Hospital Costs

The introduction of the PPM was associated with a number of studies that examined differences between the cost of providing hospital services in the ACT and those elsewhere. A benchmarking review reported by Anderson and Brennan (2000) which compared TCH with six other peer group hospitals in the National Hospital Costs Data Collection (NHCDC), did not find any gross levels of incomparability in casemix costing between TCH and other hospitals in the Peer Group. However, it also suggested that there was a need to consider strategies for addressing identified differences between TCH and other Peer Group Hospitals (Anderson and Brennan 2000:18). Also, there was an unpublished study by Morgan and Chin in 2000, in which seven factors that could explain the difference between ACT and other hospital costs were identified. Six of these were differences in:

- outcomes and quality;
- patient care;
- recording of episodes of care;
- comparability of costs that should be included in DRG costs;
- economies of scale for certain high cost DRG; and
- efficiency.

The seventh factor was methodological and statistical issues impacting on the validity of comparisons.

In response to concerns about how appropriate were the various comparisons made of hospital costs in the ACT and elsewhere, the Board commissioned NATSEM to review the methodologies relating to public hospital costs in relation to the CGC, the NHCDC, and the Australian Institute

of Health and Welfare (AIHW). In its report it was noted that while none of the above methodologies were intended to be used for benchmarking, the figures they produced were often interpreted by the media and other organisations as suggesting that ACT hospitals were much less efficient than hospitals nationally (Waters et al. 2001:iii). The report argued that comparing ACT hospital costs with national average costs was not comparing like with like. It also suggested that:

> In the longer run it would be more desirable to benchmark at the clinical service level. This would provide a more robust result than comparing entire hospitals with each other, given the difficulties in defining appropriate peer groups for the ACT hospitals (Waters et al. 2001:56).

Furthermore it argued that:

> Benchmarking requires rigorous methodology, ownership by those affected and comparison of like with like, including how services are defined and costed. Effective benchmarking is thus resource intensive and requires a collaborative approach between management, clinical specialists and allied health professionals (Waters et al. 2001:60).

Community Services

The intention of DHCC to make better use of benchmarking in regard to community services was thwarted by a lack of a robust model. During the PPM period, DHCC was hopeful it could develop a model in collaboration with ACTCC (ACT Government 2000c:6, and 2001h:6). However, while ACTCC had developed an activity-based costing model based on one used by the Brisbane City Council to help with its tendering, it never provided details of the model to DHCC. During interviews three reasons given for this were that the model:

- was labour intensive and time consuming;
- not always suitable for tendering; and
- showed that DHCC had a high level of overhead and infrastructure costs that were related to the small size of the ACT (interview comment: senior managers ACTCC).

Furthermore a senior executive of ACTCC stated that ACTCC tried to keep DHCC at bay on costs because DHCC wanted to go into too much detail, and there was a concern that the information might be misunderstood and/or misinterpreted by DHCC (interview comment).

No evidence was found of attempts by DHCC to develop arrangements for benchmarking services provided by non-government providers. However, during interviews several non-government providers suggested that because of the specific nature of the ACT, it was difficult to benchmark their services against non-government providers elsewhere. Several had tried to benchmark their services against similar providers in the ACT. Those that had benchmarked their services against ACTCC considered that they provided services at a much lower cost than ACTCC.

SUMMARY

This Chapter provided data related to resource allocation issues that were associated with the administrative architecture the PPM was designed to develop. It identified a number of problems that illustrate the crucial part that the administrative architecture plays in the implementation of public policy; in this case, the need to give adequate attention to the resource allocation arrangements through which public policy is implemented. It focused on issues related to:

- Clearly specifying purchase requirements
  - in terms of outputs; and
  - in contractual documents;
- Purchasing services that
  - focus on consumer's needs; and
  - are at contestable prices.

The use of output specification to provide a clearer indication of the services the government was buying and their costs was subject to major limitations. The DRG system used to specify hospital outputs was of little benefit because the costs of outputs used were averages over a number of hospitals. Thus in purchasing hospital outputs arbitrary adjustments had to be made for ACT factors. Moreover, there was considerable opposition to the approach from the medical profession. The use of output specification for the services purchased from non-government providers was also subject to limitations. Outputs were often specified in terms of activities that were difficult to aggregate. Moreover, the prices paid for outputs purchased by

DHCC often only represented a contribution to the operations of the provider, and not a real price.

Inexperience of DHCC and providers (especially during the early stages of the PPM), demand uncertainty, resource constraints, and lack of robust cost data, made it difficult for DHCC to accurately specify purchase requirements and prices in contracts. However, especially as DHCC and hospital providers became more experienced, lack of agreement over pricing issues resulted in lengthy delays in the finalisation of hospital contracts and especially the contract between DHCC and TCH. The finalisation of contracts long after the start of a contract period limited their usefulness as a resource allocation tool.

There were inherent problems in both determining and meeting consumer needs. For example, there were particular problems in determining mental health needs and the needs of services provided by non-government providers because of a lack of robust information. Also, in meeting consumer needs, constraints on government funding resulted in the need for rationing, and (especially in relation to community services) there was often a lack of appropriate guidelines to effectively achieve this objective. Furthermore at times arrangements to meet consumer needs clashed with the goal of seeking value for money.

Contestable purchase arrangements (competition and benchmarking) had only a limited impact under the PPM. Competition was largely confined to one small tender for hospital services, and the use of new-money for some services predominantly provided by non-government providers. Competition was limited because of:

- conflicting policy objectives such as role delineation;
- internal hospital arrangements, especially for elective surgery, made it difficult;
- concerns of doctors and health insurers about the treatment of public patients in private hospitals, especially where overnight stays were involved; and
- concerns of non-government providers about the impact of competition on provider cooperation.

Benchmarking was largely an ineffective tool because of the atypical nature of ACT hospital arrangements. Furthermore, benchmarking was never successfully used in regard to community services because of a lack of a robust model. In the next Chapter data is provided that relates to issues associated with the performance management framework that forms part of the PPM administrative architecture.

Chapter 7

Performance Management

This is the third of three Chapters providing empirical data to support the thesis argument that the administrative architecture through which public policy is implemented plays a crucial part in its implementation. This Chapter provides data related to issues associated with the performance management framework that was part of the PPM approach and consequently part of the administrative architecture it was designed to develop. The detailed analysis of the data in Chapters 5, 6 and 7 and related comment in the Literature Review (Chapter 2), occurs in Chapter 8.

This Chapter provides data on:

- Separation of ownership and purchase objectives;
- Use of contracts as a performance management tool ;
- Specification of performance in output terms;
- A move to a managerial accountability approach; and
- Use of meaningful performance measurement.

In addressing each of these issues the Chapter provides an overview of the policy goals, the nature of the arrangements (the means and instruments used to achieve these goals), and the impact of arrangements during the implementation process (the impact of both the policy goals and the means and instruments used).

In brief, the data show that:

- ownership and purchasing objective separation appeared to serve no useful purpose – for government providers it caused unnecessary complications;
- contracts tended to provide more benefits to DHCC than to providers;

- an output focus gave a better understanding of provider activity, but defining outputs and relationships between outputs and outcomes was difficult;
- the managerial accountability approach taken by DHCC was a hybrid system – providers were accountable for results and how money was spent; and
- the extent to which arrangements resulted in more meaningful performance measures was doubtful, with political accountability needs often overshadowing managerial accountability requirements.

SEPARATION OF OBJECTIVES

Policy Goal

The policy goal of separating objectives was to provide greater performance clarity for government entities, by separating the Government's objectives as an owner and investor in public sector entities, from its objectives as a purchaser of goods and services (ACT Chief Minister's Department 1996:10).

Nature of Arrangements

The separation of ownership and purchasing objectives as part of the performance management framework only applied to the government entities DHCC, TCH (including ACTMHS), and ACTCC. The ownership objectives focused on ensuring that the ACT Government received the best possible return from the resources employed by government providers (ACT Government 1997e). On the other hand, the purchasing objectives were focused on achieving value for money and purchasing the minimum number of appropriate, efficiently produced outputs to achieve the ACT Government's desired policy outcomes (ACT Chief Minister's Department.1996:10; ACT Government 1996c:iv). There was one set of separation arrangements relating to DHCC, and another set relating to the government providers TCH and ACTCC.

In regard to DHCC, the objectives of the Treasurer as the owner/funder of DHCC's resources were set out in annual ownership agreements between the Treasurer and the CEO of DHCC, while the objectives of the Health Minister as purchaser were set out in purchase agreements between the Health Minister and DHCC.

In regard to government providers, the ownership objectives of the Treasurer were set out in separate contracts between the Treasurer and TCH and ACTCC. In 1996-97 and 1997-98 these contracts took the form of ownership agreements, whereas, between 1998-99 and 2001-02 the contracts took the form of Statements of Intent, which were required from statutory authorities under Section 58 of the ACT *Financial Management Act 1996,* with Sub-Section 58(3)(c) of the Act requiring ACT Authorities to provide the Treasurer, in respect of each financial year, 'a statement of the objectives of the authority for the year.'

The purchase objectives of government providers were set out in purchase agreements between DHCC and government providers (TCH and ACTCC). These providers were also responsible to the Board (of ACTHCCS) which had responsibilities that were interpreted as being somewhat akin to DHCC. In turn all three (TCH, ACTCC and the Board) were subject to the Health Minister's direction under sub-section 14.1 of the ACT *Health and Community Care Services Act 1996*. Furthermore, as stated in the explanatory memorandum to this Act, under S.6, the ACTHCCS was:

> required to give the Minister information relating to its operations as the Minister requests and to submit to the Minister proposals regarding the nature and extent of its future operations (ACT Legislative Assembly 1996a:4).

Impact of Arrangements

In terms of performance management, the separation of ownership and purchasing objectives appeared to be of far less impact on DHCC than on the government service providers (TCH & ACTCC). Accordingly, separate consideration has been given to the impact of the separation arrangements on DHCC, and on government service providers.

Impact on DHCC

The separation arrangements resulted in the Treasurer setting the objectives of DHCC from an ownership perspective in consultation with the Health Minister, and the Health Minister setting the objectives of DHCC in regard to the goods and services that need to be purchased.

Treasury saw the ownership agreement with DHCC as forming a useful purpose (interview comment: senior executive Treasury). However, a senior executive of DHCC saw no reason why the Treasurer should be involved in the performance management of DHCC through an ownership agreement. As noted in Chapter 5 chief executives of departments were responsible to the Ministers of their Department for the effective financial management of their departments under Section 31 the ACT *Financial Management ACT 1996,* whereas, there was no legislative requirement for an ownership agreement (interview comment). Moreover, as noted earlier, Weeks and Anderson (1995:21) assumed that management reforms for the ACT health sector would involve the Health Minister having both ownership and purchasing responsibilities. So, there appeared to be no strong reason why the Health Minister could not be responsible for managing the performance aspects of both the ownership and the purchasing interests of the ACT Government in DHCC.

Impact on TCH and ACTCC

As indicated earlier, the aim of separating ownership and purchasing objectives in relation to the activities of TCH and ACTCC was to provide greater performance clarity. However, the extent to which having separate performance objectives provided this appeared doubtful as the ownership objectives of the Treasurer appeared to be equally suitable as objectives of a purchaser: For example, an examination of the ownership objectives for TCH and ACTCC in contractual documents shows that for example, in the Ownership Agreements/Statements of Intent between the Treasurer and TCH for the period 1996-97 to 1999-00, the major corporate objectives/key result areas (which were almost identical to those of ACTCC for the period 1998-99 to 2000-01) were:

- to continually provide high level, cost efficient and effective health and hospital services to the ACT and South-Eastern Region of NSW;
- to provide value for money;
- the community knows what we do, supports what we do and judges that we do it well;
- to maximise our customers' well being and health; and
- to enable our staff to achieve excellence.

In 2000-01 and 2001-02 Statements of Intent for TCH contained the following performance goals:

- Pursue consumer focused health care;
- Make best use of available resources;
- Provide efficient, effective, accessible and quality acute care; and
- Be a learning and innovative organisation (ACT Government 2001d:3).

Also for 2001-2002 there were the following five performance objectives in the Statement of Intent for ACTCC:

- Effective clinical and corporate governance;
- Provide quality and cost competitive services;
- Enhance health, wellness and independence outcomes;
- Enhance client relationships (including carers, parents and families); and
- Foster a culture which reflects ACT Community Care values (ACT Government 2001i:5).

During interviews, a senior executive of ACTCC expressed the view that there appeared to be no reason why ownership and purchasing objectives were not the same, suggesting that 'the approaches represented different methodologies.' Also, because of the responsibilities of the Health Minister, The view in DHCC was that the Treasurer (and Treasury) didn't need to have a performance management function through a Statement of Intent with government providers. (interview comments: senior executive DHCC).

While purchasing objectives for services purchased from DHCC, TCH, and ACTCC (and non-government providers) were included in purchase agreements between the parties, the Health Minister was also given considerable responsibilities relating to the activities of TCH and ACTCC under the ACT *Health and Community Care Act 1996,* which when used tended to blur his responsibilities and the responsibilities of DHCC in regard to performance objectives. Therefore it is not surprising that under the arrangements put in place the Health Minister was seen as taking a "hands on" approach especially to the activities of TCH (interview comment: senior executive of DHCC).

As part of the administrative architecture in place the Health Minister met weekly with the CEOs of TCH and ACTCC. The CEO of DHCC attended these meetings every second week. This formal and ongoing contact between the Minister and the CEOs of TCH and ACTCC was seen by DHCC as providing an opportunity for matters in purchase agreements between

DHCC and government providers to be ignored. During an interview the comment was made that the Health Minister often ignored what was in the purchase agreement in what he did and that overall the arrangements between the Minister and the CEOs of TCH and ACTCC made it hard for DHCC to implement its policy objectives within the PPM (interview comments: senior executive DHCC).

USE OF CONTRACTS

Policy Goal

The main goal of using contracts in the performance management framework associated with the PPM was to provide an open and transparent way to establish agreed directions and priorities for health and community care, (ACT Government 1996c:i).

Nature of Arrangements

The two main forms of contracts used as part of the performance management framework were ownership contracts and purchase contracts. Ownership-type contracts included the agreed performance management arrangements between the Treasurer and DHCC for its activities, and between the Treasurer and TCH and ACTCC for their activities. As noted earlier these latter “contracts” were referred to as Statements of Intent.

As noted earlier, purchase contracts operated at two levels. At the first level, there was an agreed contract between the Health Minister and DHCC that set the performance management requirements related to the activities of DHCC. At the second level, there were agreed contracts between DHCC and providers. The agreed directions and priorities in these contracts were seen as an integral part of the performance management framework associated with the PPM (ACT Government 1996c:viii-x). In particular the contracts set out the agreed:

- broad policies and principles underpinning the purchasing arrangements;
- outputs and outcomes to be achieved;
- performance measures that were to be used; and
- reporting arrangements that were required.

For non-government providers there were contract type arrangements (service agreements) with Calvary prior to the introduction of the PPM. However, with other non-government providers there were no formal contract arrangements.

Impact of Arrangements

As indicated above, from a performance management perspective, the use of contracts was expected to provide greater transparency and agreed direction and priorities. In this segment of the Chapter these issues are considered, with a focus on contracts between DHCC and providers.

Greater Transparency

The use of contracts did provide an opportunity for greater transparency in regard to performance management arrangements. For example, in purchase agreement contracts between DHCC and TCH and Calvary in 2000-01 and 2001-02, there were extensive schedules which set out the policies and principles for hospital care, and details of performance indicators and reporting arrangements. The inclusion of a substantial schedule (27 pages in 2001-02 and 36 pages in 2001-02) covering public acute care health services in the ACT in the purchase agreements was justified by a senior executive of DHCC on the basis that it was a way of ensuring that providers became aware of the outcomes the ACT Government and DHCC wished to achieve. Furthermore, a then-Opposition politician suggested that these schedules provided more useful information than the Annual Report of DHCC (comment during informal discussion).

While DHCC attempted to provide more transparency through the use of contracts, it appeared to give a different impression to providers. A director in an operations area in TCH (who was associated with contract negotiations) expressed a view that contracts between DHCC and TCH were full of padding. Also some aspects of contracts appeared to be seen by non-

government providers as often lacking in transparency. For example, the outcomes that DHCC sought were seen as often no more than “motherhood statements” (interview comment: non-government provider and staff member of DHCC). Further, the approach taken to reporting arrangements in contracts, which predominantly sought quantitative information, was seen as taking qualitative aspects out of performance reporting (interview comments: non-government providers).

Agreed Directions and Priorities

As indicated earlier, the use of agreed directions and priorities in contracts allowed DHCC to be very specific in stating what it wanted. Especially in regard to non-government providers, this was seen as making them:

- more business like and accountable;
- look at their performance and what their workers do; and
- clean up a lot of poor practices (interview comments: non-government providers).

However, because of the dominant role DHCC played in contractual arrangements, the performance management provisions that DHCC wished to include in contracts were often of concern to providers. Indeed contracts were often seen as the result of no real negotiations, one-sided in favor of DHCC; lacking flexibility; and containing onerous requirements (interview comments: non-government providers and Chairman of Board). Furthermore:

- it was suggested by a non-government provider of mental health services that there was not enough discussion with providers about what was in the contract;
- a provider of community care services was concerned about the constraints on time to discuss contract details with the organisation’s management committee, because DHCC was always in a hurry;
- a senior executive of ACTCC said that contracts written by DHCC had very explicit targets, consequently, there were very serious discussions with DHCC about contracts, as ACTCC did not want to sign up to impossible tasks;
- an interviewee involved with hospital management saw DHCC as too authoritative and the reporting arrangements in purchase agreements as burdensome;
- several non-government providers referred to the onerous nature of reporting arrangements in contracts, with one provider claiming that reporting arrangements took hours of time, and another noting that no additional funding was provided when more onerous conditions were put in contracts; and

- a senior Board member saw the agreed directions and priorities in contracts with TCH as an attempt by DHCC to micromanage TCH and to reduce its flexibility (interview comments).

Providers were not alone in having concerns about directions and priorities in contracts. DHCC was concerned about the extent to which providers complied with agreed contract provisions concerning directions and priorities. First, it was noted that government providers (and TCH in particular) were not directly accountable to DHCC (interview comment: senior executive DHCC). To counter this concern, especially in the last two years of PPM arrangements (2000-01 and 2001-02), DHCC included substantial schedules in contracts. These schedules set out the policies and principles that underpinned the direction and priorities that DHCC wanted these providers to follow (ACT Government 2000b: Sch3; ACT Government 2002a: Sch 2).

Second, while contracts between DHCC and non-government providers included agreed directions and priorities, an executive of DHCC was concerned that in providing services, non-government providers sometimes did what they saw as their agenda rather than what was the agenda of the government and the agreed agenda in contracts (interview comment). Also, from a performance management perspective, a long standing non-government provider suggested that there was a problem of non-government agencies not fulfilling their contracts that had not been fully resolved. It was claimed that DHCC appeared reluctant to “come down heavy” and “pull back” the contracts of people who did not fulfil them (interview comment). However, enforcing contracts with non-government providers did not appear to be an easy task in many instances. Often other activities the provider undertook were intertwined with the services purchased from DHCC and as noted in Chapter 6 the funding given to providers often only represented a contribution towards the cost of the services purchased so the specification of the services purchased in contracts was often somewhat artificial. Further, a senior person involved with health services in the ACT suggested that the de-funding of non-government providers could be fraught with political consequences (comment during informal discussion).

PERFORMANCE SPECIFIED AS OUTPUTS

Policy Goals

The main policy goals were to:

- move away from a performance focus related to inputs and program achievement to one related to outputs and outcomes for clients (DHCC 1995:7; ACT Government 1996d:6); and
- highlight the strategic importance of what agencies did (ACT Chief Minister's Department.1996:12).

Nature of Arrangements

As part of PPM arrangements, performance was specified as outputs in documents such as ACT Budget papers, and contracts between DHCC and providers. There was also some variation in the way outputs were specified.

In ACT Budget papers outputs were specified in terms of quantity, quality/effectiveness, and timeliness, with estimated outcomes for the previous year, and in terms of targets for the current year. Moreover, there were a small number of output quantity measures for hospital and mental health services. Output quantity measures for community care services were classified by activity/program, with a small number of output quantity measures for each activity/program. The cost of outputs was shown in aggregate as "Total Cost" and "Government Payment for Outputs".

In purchase agreements, the outputs that DHCC wished major providers (TCH, Calvary, ACTCC and ACTMHS) to supply, were specified in schedules to purchase agreements. Hospital services were specified in terms of quantity and price. Services provided by ACTCC were specified in terms of volume/quantity, quality (and timeliness, in the first year of the PPM). Mental health services were not separately specified in the purchase agreements between DHCC, and TCH (for ACTMHS) and Calvary until 1999-00. Then, they were specified in terms of outputs and cost for ACTMHS, and activities for Calvary (ACT Government 1999a:41-47; ACT Government 1999b:38).

For non-government providers outputs were often specified in terms of activities, and then further classified in quantity and quality terms. For example, for one provider that was contracted to supply "education,

information, and referral services", the output quantity was expressed in terms of "occasions of service" and quality was expressed as "compliance with national performance standards" (extract from contract). However, in an early contract examined during field work, outputs were further classified not only in terms of quantity (number of contacts) and quality (compliance with national performance standards) but also in terms of unit cost, and timeliness (same day response to phone calls).

Impact of Arrangements

The specification of performance as outputs provided DHCC with a means of identifying the services providers were expected to supply. A senior executive of DHCC suggested that prior to the focus on outputs, purchasers had a poor understanding of what providers did, but following the focus on outputs DHCC obtained a better and closer view of what providers did. It was suggested by one non-government provider that the specification of performance as outputs made organisations look at their performance and led to a greater clarification of what workers did (interview comment). However it was not always easy to define outputs or to relate outputs to outcomes.

Defining Outputs

As noted above, the use of outputs as a performance measure was seen as providing a better indication of what providers did than the use of inputs. The provision of hospital services was an area where use of DRG provided a basis for specifying performance in terms of descriptive outputs together with their quantity and cost. However, there were, as noted in Chapter 6, problems in obtaining robust cost data for the ACT, which severely limited the use of DRG there. Moreover, there were problems in defining outputs in other areas. A senior executive of DHCC argued that describing what everybody did in output terms was difficult, claiming that there was an information imbalance in favour of the providers, so purchasers did not always know what providers did (interview comment).

An area where there were particular problems in defining outputs in a meaningful manner was in relation to outputs supplied by non-government

providers. It was suggested by a board member of a non-government provider organisation that under the previous grants system there was no clear specification of a project or what it involved, so, when the PPM was first implemented DHCC had a poor understanding of what non-government providers did. Because of this corners were cut, .and it was often left to providers to say what outputs they would meet. Consequently, outputs were often measured as “hours of activity” or “numbers of phone calls”, and it was often hard for bureaucrats to work out whether outputs made sense or were relevant (interview comment).

One non-government provider whose outputs were expressed in terms of “occasions of service” was concerned that it was penalised because, at the insistence of DHCC, in the organisation’s contract an incoming call was counted but an outgoing call was not (interview comment). A number of other more general concerns were also raised by non-government providers about the difficulties in defining the outputs that non-government providers supplied. There were concerns that:

- there was a lack of a glossary for recording outputs;
- governments had unsuccessfully tried for many years to get output measures for community care; and
- the notion of outputs was an industrial term that was more meaningful in manufacturing industries, and was far less relevant in human services (interview comments).

Outputs and Outcomes

While under PPM arrangements outputs were expected to be related to outcomes, this was often difficult from the purchaser’s perspective, especially in relation to services provided by non-government providers. During interviews:

- A board member of a non-government organisation claimed that while the PPM put obligations on non–government providers to be more specific and to identify what benefits a proposal would bring, that often did not happen;
- A senior administrator in TCH suggested that deciding what outputs should be purchased and how to achieve outcomes was difficult as power politics and sectional interests needed to be taken into account; and
- A senior executive of DHCC said that under the PPM approach, DHCC tried to focus on outcomes, but had to focus on outputs, resulting in it measuring things.

From the providers perspective the focus on outputs was often seen as providing results that were not related to the outcomes they were trying to achieve:

- A senior executive in ACTCC expressed the view that the use of outputs in budget papers was farcical as they didn't give a good indication of what was delivered;
- a senior doctor saw the focus on outputs as a lack of understanding of the purpose of health care;
- a director in ACTCC considered that a focus on outputs was a focus on numbers – it did not show that health had improved;
- one non-government provider suggested that the use of outputs such as "hours of activity undertaken" were seen as having little relationship to the outcomes providers were trying to achieve; and
- a long-standing non-government provider; suggested that activities became output-driven at the expense of outcomes, argued that (because reporting was output-driven) workers complied with outputs rather than outcomes, and expressed the view that it was a strain to try to achieve both outputs and outcomes (interview comments).

MANAGERIAL ACCOUNTABILITY APPROACH

Policy Goals

The implementation of a managerial accountability approach was designed to:

- introduce a system that involved accountability with responsibility – a more business-like system (Weeks & Anderson 1995:14);
- ensure that those with delegated authority were carrying out agreed tasks in accordance with agreed performance criteria, and with providers held accountable to purchasers (Ferlie et al. 1996:198); and
- pursue accountability to customers (ACT Government 2001h:4).

Nature of Arrangements

Under the PPM, the managerial accountability approach involved three major accountability arrangements. First, in relation to purchasing arrangements, there were accountability commitments in regard to output requirements identified in the ACT Budget. As part of these arrangements the CEO of DHCC was accountable to the Health Minister for ensuring that outputs consistent with ACT Budget requirements were purchased (ACT Government 1998f:3). In turn, government and non-government providers were accountable for meeting the contractual requirements specified by DHCC.

Second, in regard to ownership arrangements, under Section 31 of the ACT *Financial Management Act 1996,* the CEO of DHCC was responsible for the

efficient and effective financial management of DHCC. The CEO was also accountable to the Treasurer to ensure the Government received the best possible return from the resources employed by DHCC through the efficient and business-like management of those resources, and the prudent management of financial risk to the ACT (ACT Government 1996h:3). Furthermore, under Section 54 of the ACT *Financial Management Act 1996* the CEOs of government providers (TCH and ACTCC) were responsible through ACTHCCS for the efficient and effective financial management of their agency, and accountable to the Treasurer for the efficient and business-like use of their resources.

Third, DHCC frequently became accountable to customers through arrangements put in purchase agreements. In this regard providers were required to have adequate consumer complaints mechanisms in place. In addition major providers (TCH Calvary, & ACTCC) were required to put arrangements in place to provide greater involvement of consumers and to undertake annual customer surveys. However, while non-government providers were not required to undertake consumer surveys, some did for their own purposes (interview comment).

Impact of Arrangements

Using a managerial accountability approach for the purchase of services was expected to make providers accountable for what they supplied rather than how money was spent. However in its approach under the PPM, DHCC required providers from whom it purchased services to provide detailed information on their finances on a regular basis (ACT Government 1996f:67; ACT Government 2001h:4). Furthermore, under the provisions of the standard contract, for non-government providers other than Calvary, providers were required to supply a cash/financial statement providing full details of expenditure related to the purchase price, and an annual audit report that included an opinion as to whether the purchase price had been expended in a manner required by the contract (extract from contract of non-government provider, entered into on 1 July 2000).

In summing up the approach taken by DHCC, an executive officer of a peak non-government organisation expressed the view that the system used in the ACT was a hybrid one. DHCC wanted to purchase a product, but also wanted to know where money went to produce it – there was a tendency for DHCC to try to micromanage the activities of providers (interview comment). Moreover, in addition to such a hybrid system of accountability (as will be discussed later in this Chapter) DHCC often let political accountability needs overshadow managerial accountability needs in regard to the reporting activities of government providers.

While arrangements for accountability to customers under the PPM included DHCC operating as a proxy consumer, as noted earlier the associated arrangements were largely dependent on those put in place by providers and especially those put in place by the major providers (TCH, Calvary and ACTCC). However, (as discussed in more detail in Chapter 5) representatives of the Health Care Consumers Association ACT Inc. were particularly concerned about the approach to consumer satisfaction surveys which they considered was lacking, and needed to provide more meaningful results (interview comment).

The accountability to customers approach taken under the PPM also appeared to be seen as cutting across conventional arrangements in the health sector. A senior doctor expressed the view that the managerial accountability approach under the PPM was part of a system of management that was not designed around the patient (interview comment). In this context, Nancarrow (2001:132), who examined allied health care arrangements associated with the PPM in the ACT, noted that clinical professionals saw themselves as having multiple accountabilities which included direct accountability to their patients. Furthermore, the Secretary of the ACT Branch of the Australian Nursing Federation stated that nurses had a dual responsibility of maintaining a level of care to patients and keeping within budget (interview comment).

MEANINGFUL PERFORMANCE MEASURES

Policy Goals

The implementation of the PPM was expected to provide more meaningful performance measures as part of the performance management framework, mainly through the use of performance measures that:

- had a clear purpose in that they were related to the timely and accurate measurement of output delivery and covered all significant aspects of performance;
- were meaningful in number; and
- provided a basis for accountability (ACT Chief Minister's Department 1995c:8 and 1996:18).

Nature of Arrangements

As part of the focus on the above goal, under PPM arrangements attention was given to performance measurement from the perspective of the:

- ACT Government, in the ACT Budget;
- Purchaser; and
- Owner.

Performance Measurement and the ACT Budget

Performance measurement from the perspective of the ACT Government was reflected in ACT Budget papers with output performance measured in terms of quantity, quality/effectiveness, timeliness and cost (ACT Government 1996b:103). The intention was to assess each output in terms of:

- quantity – how much or how many;
- quality – how well;
- timeliness – how often;
- price (cost) – total price (cost) or price (cost) per unit (ACT Chief Minister's Department 1995c:6).

The extent to which performance measures were achieved was shown in the Annual Reports of DHCC. These reports included performance targets, results, variance from target and an explanation of material variances. However, separate performance measures for output classes such as hospital, community care and mental health services were not introduced until the second year of the PPM (1997-98).

Performance Measurement: the Purchaser's Perspective

From the perspective of DHCC as purchaser, performance measures were included in purchase agreements between DHCC and Providers. However, the approach to the use of performance measures varied. For hospital providers (TCH and Calvary) performance measurement requirements were set out in a schedule attached to the contract with DHCC. A substantial increase in the number of performance measures was a feature of performance measure arrangements over the period of the PPM. In 1996-97 when the PPM was first implemented there were for:

- TCH 19 performance indicators with 27 productivity and quality targets associated with 8 service priorities; and
- Calvary 22 performance indicators with 29 productivity and quality targets associated with 8 service priorities (ACT Government 1996c:34-42; 1996f:38-45).

By 2001-02 the number of performance indicators had grown. There was a 70 page schedule with a three page introduction. The number of performance indicators for:

- TCH was 67, which were related to 27 areas and activities, and 43 pages of data source specifications; and
- Calvary was 36, which were related to 14 areas and activities and 43 pages of data source specifications-(ACT Government 2002a: Sch 3: 2001b Sch 3).

For community care services provided by ACTCC, performance requirements were related to service groups/programs. There were separate volume/quantity, and quality performance indicators for each component/output of ACTCC service groups/programs, such as the alcohol and drug telephone line in the alcohol and drug program. In the first year of the PPM (1996-97) ACTCC also included timeliness as a performance indicator (ACT Government 1996g). In the final year of the PPM (2001-02), the focus on components of programs was retained. However, there was a much more structured and detailed approach to performance measurement with measures related to their policy content and desired outcomes (ACT Government 2001h). In contrast to hospital services there were a large number of performance indicators for ACTCC right from the start. There were:

- in 1996-97, 148 volume, 178 quality and 107 timeliness performance measures related to 10 service groups; and
- in 2001-02, 133 quantity 145 quality and other 30 other performance indicators related to 9 programs and 105 outputs (ACT Government 1996f:Sch. 2; 2001h Sch. 2).

Performance requirements for ACTMHS were included in contracts between DHCC and TCH. However, there were no separate arrangements for mental health services provided by Calvary. For non-government providers of community care and mental health services (other than Calvary), performance indicators were expressed in terms of quantity and quality, which were often related to performance/quality standards. Also, in early contracts performance indicators were related to timeliness (non-government provider contracts, examined during field work).

Performance Measurement: the Owner's Perspective

As noted earlier, for 1996-97 and 1997-98 there were ownership agreements between the Treasurer and government providers. However, there were no performance measures in these documents. Thus, from the owner's perspective, performance measures were included in the Statements of Intent. For TCH, in 1998-99 and 1999-00, for each corporate objective there were performance measures related to strategies and service areas such as surgical services, medical services and nursing services. For 2000-01 and 2001-02, for each goal there were performance indicators related to key objectives and strategies. Especially in 1998-99 and 1999-00 there was a very large number of performance measures. The annual reports of ACTHCCS reported on the extent to which performance measures were achieved by performance measure, target, result, variance, and comments on variance. In the last two years of the PPM the performance measures reported in the annual report of ACTHCC for TCH reflected an amalgamation of performance measures in the Statement of Intent and the Corporate Plan of TCH.

For ACTCC, there were financial performance measures related to profitability, liquidity and financial stability. There were also non-financial performance measures related to its five corporate goals/strategic objectives and 19 strategies associated with these goals/strategic objectives. While the strategies remained the same over the PPM period, the names of the goals changed in 2001-02 and they were referred to as strategic objectives.

During the period 1998-99 to 2000-01 the goals were:

1. Continually improve our services based on outcomes, quality and customer commitment;
2. Provide value for money;
3. Maximize our customers' independence, well being and health;
4. The community knows what we do, supports what we do and judges that we do it well; and
5. Enable staff to achieve excellence (ACT Government: 1998g:4; 1999e:5; 2000e:5).

In 2001-02 the strategic objectives were:

1. Effective clinical and corporate governance;
2. Provide quality and cost competitive services;
3. Enhance health, wellness and independence outcomes;
4. Enhance client relationships (including carers, parents, and family); and
5. Foster a culture which reflects ACT Community Care values (ACT Government 2001i:5).

The numbers of non-financial (business and corporate) performance measures were: 22 in 1998-99 and 1999-00, 21 in 2000-01 and 20 in 2001-02. The bulk of these performance measures (14 in 1998-99 and 15 in other years) related to the third goal/strategic objective above. For this goal, performance measures were expressed as quantitative outputs for programs undertaken by ACTCC. For example, the first of these measures was related to the average number of registered methadone treatment clients. While this measure was related to the alcohol and drugs program, performance measures were not categorised by program and there were between one and three performance measures per program in the Statement of Intent that related to goal/strategic objective 3 referred to above and on the previous page.

The extent to which performance measures were met was published in the annual report of ACTHCCS in the same format as those for TCH. Until 2001-02 the only performance indicators published were those relating to the objectives of ACTCC. However, in the 2001-02 annual report of ACTHCCS there was a second set of performance measures at the end of the discussion of each program. For example, for the alcohol and drug program, the annual report of ACTHCCS contained performance measure reports on:

- the three alcohol and drug related performance measures in the Statement of Intent, as part of the financial statements.
- eleven quantitative and cost related performance measures at the end of the section on the Alcohol and Drug Program, which included the three performance

> measures reported on as part of the financial statements (ACT Government 2001e:151).

Impact of Arrangements

As noted above, the implementation of the PPM resulted in performance measures that focused on performance from the perspective of:

- the ACT Government through the ACT Budget;
- DHCC as Purchaser; and
- Treasury as Owner.

The ACT Budget Perspective

While there were output performance measures in terms of quantity, quality/effectiveness, timeliness and cost in ACT Budget papers, each of these measures was applied to a different output. For example, in the 2001-02 ACT Budget for hospital services there was:

- a *quantity* performance measure for inpatients: 'the number of inpatient cost weighted separations';
- an inpatient *quality/effectiveness* performance measure: 'Rate of unplanned hospital readmissions';
- an inpatient *timeliness* performance measure: 'The percentage of patients in the emergency departments seen within standard timeframes' or within 'clinically desirable time frames' for the most urgent cases; and
- a *cost* performance measure related to total cost for all hospital services per 1,000 head of population (ACT Government 2001c:125, italics added).

So, the specification of performance in terms of the output measures quantity, quality/effectiveness, timeliness and cost became a method of categorising different performance measures, rather than a means of providing different dimensions for the performance measurement of one output. For example, the above performance measures gave no indication of the quantity/number of patients attending the emergency department.

There was only one cost performance measure for each of hospital, community care, and mental health services (ACT Government 2001c:125-128). These performance measures were in effect measures related to the amount of money that was appropriated to these services. It was an approach which, in effect, treated these services as programs. Furthermore, ACT Budget performance measures of "quantity" for community care

services were (as noted in Chapter 6) categorised within a program structure (ACT Government 2001c: 127-128).

The Perspective of DHCC as Purchaser

The implementation of the PPM had a major impact on the performance measurement needs of DHCC and also led to issues related to quality performance measures.

Performance Measurement Needs of DHCC

From the perspective of DHCC as purchaser, its arm's length relationship with government providers, and their lack of direct accountability to DHCC, provided a perceived need for DHCC to have considerable performance measurement information to provide it with a better understanding of what these providers did and to have information that allowed it to meet political accountability needs (personal observation based on a range of interview comments). For example one consultant claimed that under PPM arrangements DHCC lacked easy access to performance information for political accountability purposes (Interview comment).

As a consequence of its information needs, in the final year of the PPM approach there was a 70-page schedule in DHCC contracts with TCH (and Calvary) that set out performance indicators, which included 43 pages of data source specifications. In the introduction to this schedule, inter alia, it was stated that the performance requirements in the Schedule served two functions:

> Firstly, with the reports identified in this document, effective monitoring against the performance indicators can occur. Secondly, the reporting requirements allow for broader data to be gathered. This enables the Government and the Department to identify initiatives for future programs within the hospitals and across health care services.
>
> To meet both these goals, it is necessary that the hospitals supply all the reports as specified in this Reporting Requirements and Performance Indicators document at the times indicated. The Department will then be responsible for collating this information in such a way as to measure the hospitals performance against this agreement (ACT Government 2002 a:Sch 3:3).

It was also noted that the hospitals were not required to report directly against the performance indicators. Moreover, there was a requirement that in all cases the identified source document for each performance indicator

was the information the hospital was required to produce. (ACT Government 2002 a:Sch 3:3).

In a similar vein, as noted earlier, ACTCC provided a large amount of performance measure information to DHCC from the beginning of the PPM. However, in contrast to TCH it was suggested that the use of a large number of performance measures reflected both a request by DHCC for information and an approach by the internal staff of ACTCC that involved going into too much detail (interview comments: senior staff ACTCC). Moreover, it was suggested by a manager in ACTCC that ACTCC went into great detail trying to impress people and in the end "went over the top" (interview comment).

As noted earlier, the major concern of non-government providers was what was seen as an undue emphasis on quantitative performance measurement. In discussing this issue one non-government provider expressed the view that providing health related services "was not a bums on seats process." Also, another provider suggested that DHCC could get no idea of what an organisation did on the basis of quantitative information sought in contracts.

Overall, the PPM approach provided DHCC with a great amount of performance information. One of the consultants interviewed expressed the view that a large number of performance measures reflected "knee-jerk" management and suggested that in any large government organisation information is often collected in case questions on notice are asked. She further suggested that once information is collected the process is continued even though the information is no longer needed. Moreover, the approach which resulted in providers having to supply considerable performance information to DHCC was seen in a different light by the Board of ACTHCCS. It was regarded as part of what the Chairman of the Board saw as an attempt by DHCC to micromanage the activities of TCH (interview comment).

Quality Measurement Issues

The need to control quality was seen as important (interview comment: health consultant). However, under PPM arrangements the development of

meaningful performance measures fell short of expectations. A senior executive in DHCC argued that quality was a difficult issue to address. Also, a Board member expressed the view that there were very few meaningful quality performance measures, as quality (and safety) issues were not translated into performance measures, because under the PPM the focus was on throughput and cost and not quality. A similar view was expressed by a non-government provider who claimed that the Government was more interested in coverage than quality (interview comments).

The senior executive of DHCC stated that because it was hard to judge quality, DHCC often had to use proxy performance measures like accreditation (interview comment). Under PPM arrangements, TCH and Calvary were expected to maintain accreditation with the Australian Council on Healthcare Standards (ACHS) and to provide a range of services within ACHS confidence intervals (ACT Government 2002a Sch 3:7; ACT Government 2001b Sch 3:6). Furthermore, in the ACT Budget, ACHS accreditation was also a quality/effectiveness performance measure for TCH, Calvary and ACTMHS (ACT Government 2001c:125-126).

While the use of accreditation provided a form of quality assurance, the reliance on ACHS standards was questioned by a representative of Health Care Consumers Association ACT Inc., who expressed the view that ACHS was not well resourced and there was a low entry point to meet ACHS standards. It was suggested that when an organisation received accreditation it was then coaxed along to improve, as there were no punitive constraints. It was argued that there was the need for a better accreditation system than the one that was in place. It was further suggested that there was a need for a framework to protect the quality of services and a need to construct meaningful performance indicators (interview comment).

In addition to the use of accreditation, another quality performance measure used by DHCC, especially in contracts with non-government providers, was compliance with national standards such as those related to the provision of home and community care, disability and mental health services. However, the use of national standards appeared to present problems for at least some

non-government providers. For example, non-government providers were expected to comply with the National Mental Health Standards. There were 11 non-prescriptive standards covering 23 issues and 265 criteria. Providers were expected to rate the extent to which the criteria were met using a six-item rating code, which included a code for criteria that were not applicable (Commonwealth of Australia 1997:5-48). Because of the problems being faced in addressing these standards, in late 1999 DHCC provided funds to the ACT Council of Social Services (ACTCOSS) to assist non-government providers in the implementation of these standards. While ACTCOSS addressed many of the concerns of non-government providers, it was noted, in a March 2001 report on the project, that some providers had ongoing concerns regarding both the resources available for implementing the standards, and the form of monitoring and evaluation that was undertaken (ACTCOSS 2001:11).

Only a few non-government providers commented on national standards as an issue during interviews. However, those that did referred to the difficulties addressing them. One non-government provider representative interviewed in 2002 suggested that there was a lot of work required to interpret what the mental health standards meant, because they were largely written for clinical organisations. Another non-government provider (interviewed in the same year) noted that their organisation had not developed a policy on all the Standards, noting that ‘when you have people in your face you do not always have much time for policy development.’ On the other hand, one of the consultants interviewed in 2003 noted that some organisations had no problems applying the standards and felt that “problems with the standards” was used by some people, as their excuse for not applying them.

The Perspective of Treasury as Owner

From the perspective of Treasury as owner, PPM arrangements associated with performance measurement impacted somewhat differently on TCH and ACTCC.

TCH

As noted above, under PPM arrangements there were performance measures both in Statements of Intent and in the annual reports of ACTHCCS. Performance indicators were related to goals, corporate objectives and strategies. A feature of arrangements during the PPM was the degree of variation in approaches. When the PPM was introduced there were 53 performance measures. However, over the period of the PPM the number of performance measures declined to 17 in 2001-02 but the number of strategies increased from 21 in 1998-99 to 50 in 2001-02 (See Table 7.1).

Table 7.1

NUMBER OF GOALS, CORPORATE OBJECTIVES, STRATEGIES AND PERFORMANCE MEASURES IN STATEMENTS OF INTENT FOR TCH 1998-99 to 2001-02

Year	Number of			
	Goals	Corporate Objectives	Strategies	Performance Measures
1998/99	(a)	5	21	53
1999/00	(a)	5	19	40
2000/01	4	14	46	13
2001/02	4	14	50	17

Note: (a) prior to 2000-2001 there were not separate goals and objectives in Statements of Intent.

Source: Statements of Intent between the Treasurer and the CEO of TCH for the period 1998-99 to 2001-02

Furthermore, in 2000-01 and 2001-02 TCH attempted to align its strategic plans with Statements of Intent (interview comment: CEO TCH). However, while the goals were aligned, the performance indicators were not. There were two reasons for this. First, there was a timing issue. The Statement of Intent lagged the Strategic Plan (Interview comment: senior officer Treasury). For example, the Statement of Intent for 2001-02 was published in April 2001 and based on the Strategic Plan for 2000-01 published in July 2000. Second, there was a vetting issue. The performance measures in both the Statement of Intent and the Annual Report of ACTHCCS were a modified version of those in the Strategic Plan. Therefore in 2000-01 and 2001-02 there were different numbers of performance indicators in each of these documents (See Table 7.2).

In fact an analysis of performance measures for 2001-02 in the Statement of Intent, Purchase Agreements and the ACT Budget shows that there were only four common performance indicators, viz.:

- Emergency Department Waiting Times;
- Percentage of long waiting times for elective surgery;
- Maintain Australian Council of Health Care Standards Accreditation; and
- Unplanned hospital readmissions (ACT Government 2001c:125; 2001d:16; 2002a:Sch3:6-7).

Table 7.2

NUMBER OF PERFORMANCE MEASURES BY STRATEGIC PLAN, STATEMENT OF INTENT, AND ACTHCCS ANNUAL REPORT, AND BY GOAL, FOR TCH: 2000-01 AND 2001-02

Goal	Number of performance measures					
	Strategic Plan		Statement of Intent		ACTHCCS Annual Report	
	2000-01	2001-02	2000-01	2001-02	2000-01	2001-02
Consumer focused health care	3	9	2	2	2	4
Best use of available resources	4	22	1	3	1	5
Efficient, Effective, Assessable and Quality acute care services	9	29	7	6	7	8
Learning and innovative organisation	6	14	3	6	3	4
All categories	22	74	13	17	13	21

Source: Statements of Intent for the Canberra Hospital 2000-01 & 2001-02, Strategic Plans for the Canberra Hospital 2000-03 and 2001-04 and Annual Reports of ACT Health and Community Care Service 2000-01 & 2001-02.

ACTCC

The performance measures in Statements of Intent were designed to show not only the extent to which ownership goals were met but also the performance measures that ACTCC used as a statutory authority. However, the use of separate performance measures in Statements of Intent did not appear to provide any useful purpose:

- as noted earlier, there were no major differences between the corporate objectives in the Statements of Intent, and in purchase agreements between DHCC and ACTCC;
- the performance measures in Statements of Intent that were related to the programs undertaken by ACTCC (measures related to Objective 3 referred to earlier) were a small unprioritised sub-set of those in purchase agreements between DHCC and ACTCC; and
- because Statements of Intent were, for most years of the PPM, prepared some months before purchase agreements were finalised, the

quantitative performance measures used did not always reflect the level of demand contracted for in a particular financial year.

SUMMARY

This Chapter provides data related to issues connected to the performance management framework that was part of the administrative architecture the PPM was designed to develop. It identifies a number of problems that illustrate the crucial part that the administrative architecture plays in the implementation of public policy, in this case, the need to give adequate attention to the performance management framework through which public policy is implemented. It focuses on issues related to:

- the separation of ownership and purchase objectives;
- the use of contracts to specify performance objectives;
- the specification of performance in output terms;
- a move to a managerial accountability approach; and
- the use of meaningful performance measurement.

The separation of ownership and purchasing objectives was designed to provide greater performance clarity. However, this separation in relation to DHCC between the Treasurer and the Health Minister appeared to serve no useful purpose. There appeared to be no reason why these responsibilities could not be undertaken by the Health Minister. The separation of ownership and purchasing objectives for government service providers was also of doubtful benefit. TCH and ACTCC were dominant providers of services to DHCC and their activities were part of the mainstream business of DHCC. In addition, the Health Minister had responsibilities for government providers under the ACT *Health and Community Care Services Act 1996.* Therefore the involvement of the Treasury appeared to cause unnecessary complications.

While contracts provided a formal basis for performance management and greater transparency they were also often seen as one-sided in favour of DHCC: with limited opportunities for negotiation, with onerous requirements, and lacking flexibility. In some instance contracts were seen as being used as a vehicle to control the activities of providers.

The move from a focus on inputs to a focus on outputs provided DHCC with a better understanding of what providers were doing, and also encouraged providers and especially non-government providers to look at their performance. However, there were problems in defining outputs and developing a meaningful relationship between outputs and outcomes.

While the managerial accountability approach was designed to make managers more accountable for what they did rather than how they did it, there appeared to be a tendency for DHCC to micromanage the affairs of providers and to pursue a hybrid system where DHCC wanted to pay the price for health services and at the same time wanted to know what provider money was used for in relation to the services purchased.

Finally, while there were benefits in having meaningful performance measures (especially those that focused on output delivery); a feature of arrangements developed in contracts with the major providers was a proliferation of performance measures and reporting arrangements with political accountability needs often overshadowing managerial accountability requirements. Further, the performance measures were not set out in a prioritised format, and while the need to control quality was seen as important, its measurement was seen as difficult. As a consequence, it was necessary to place considerable reliance on accreditation and national standards, a reliance that was not without shortcomings. In the next Chapter there is a detailed analysis of the data in this Chapter and in Chapters 5 and 6, and related comment from the Literature Review in Chapter 2.

Chapter 8

Analysis

This Chapter addresses the research questions and the thesis proposition by drawing on data from interviews and documents in Chapters 5, 6 and 7 and related comments in the Literature Review in Chapter 2. In effect this allows triangulation of the data as part of the analysis. The major findings of the analysis are summarised at the end of the Chapter.

The major research question for this thesis was:

- How appropriate was the PPM as an administrative architecture for the implementation of NPM-type public policy in the ACT health area?

However, as noted in Chapter 1, to make the thesis research more manageable it focussed on what was seen as three important components of the administrative architecture, consequently the actual research questions that were separately addressed in this thesis were:

- How appropriate was the configuration of role and role relationships that was developed as part of the PPM approach?
- How appropriate were the resource allocation arrangements that were developed as part of the PPM approach?
- How appropriate was the performance management framework that was developed as part of the PPM approach?

In summary, there was ample evidence from the analysis of the three above questions to conclude that the PPM was not appropriate as an administrative architecture for the implementation of NPM-type public policy in the ACT health area. There were implementation difficulties because:

- the role separation arrangements that were part of the configuration of role and role relationships were inappropriate and largely unnecessary: they created tension and conflict that hindered rather than helped the implementation of public policy;

- resource allocation arrangements that were used were either of limited use in providing an appropriate administrative architecture because of resource constraints and the lack of robust data, or were considered to require the use of an administrative architecture that was incompatible with the PPM approach; and

- the performance management framework that was associated with the PPM approach was often either inappropriate or would have been more appropriate in relation to implementing public policy for the provision of health services in the ACT if more robust data were available.

There was also ample evidence from the analysis in this Chapter to conclude that the PPM, as an administrative architecture, through which public policy (for public health service delivery in the ACT) was implemented played a crucial part in the implementation of that policy. The analysis also indicated that the crucial part played by the administrative architecture in the implementation of public policy was more widely applicable. Many of the reasons why the administrative architecture was crucial to public policy implementation (and the PPM as an administrative architecture inappropriate) were not confined to the health area in the ACT and were often equally applicable to the health sector generally or to other areas of public service delivery. The generalisability of the results is discussed in more detail in Chapter 9.

In the analysis that follows each of the research questions is separately addressed.

ROLE AND ROLE RELATIONSHIPS

The data in Chapter 5 and comments in the Literature Review (Chapter 2) were drawn on to address the research question:

- How appropriate was the configuration of role and role relationships that was developed as part of the PPM approach?

To address this research question consideration was given to the appropriateness of the following major means (and goals that underpin them) used to develop a configuration of role and role relationships:

- role separation arrangements;
- the provision of an autonomous role for government providers; and
- provision of an enhanced role for consumers.

Role Separation Arrangements

While role separation arrangements had other objectives that are analysed later in this Chapter, the major aim of role separation arrangements was to provide greater role clarity by separating roles with fundamentally different purposes (ACT Chief Minister's Department 1995a:2; Osborne & Plastrik 1997:95-96). As part of the PPM, role separation arrangements were designed to have a major impact on relationships between:

- Politicians and Bureaucrats;
- The Purchaser and Providers; and
- Government Providers and Ministers.

Politicians and Bureaucrats

Prior to the use of the PPM approach, public policy for the provision of health services was implemented through a hierarchical relationship between the Health Minister and DHCC. Moreover, the Treasurer had no direct operational role in regard to the activities of the health portfolio. The use of the PPM approach resulted in role separation arrangements that involved the use of market-based contractual relationships between:

- the Health Minister and CEO of DHCC covering the health services the ACT Government wished to purchase; and
- the Treasurer and the CEO of DHCC covering the ownership interest of the ACT Government in DHCC.

Distinguishing between the role of the Health Minister and the CEO of DHCC in regard to purchasing activity was expected to provide greater role clarity through the avoidance of confusion and duplication. It was an approach that was in line with the view of Schick (1996:42) who asserted that such separation could reduce the fuzziness between the roles and avoid situations in which responsibility "falls between the cracks". The separation was also seen as an attempt to ensure that in the implementation of public policy, ministers were not drawn into the day-to-day operations of their departments (Schick 1996:42; Loffler 1998:10).

The data in Chapter 5 showed, that separating the roles of the Health Minister and DHCC neither provided greater role clarity, nor prevented the Health Minister undertaking a role in relation to the day-to-day operations of

DHCC (or even government providers). This was not surprising as the extent to which the roles of a minister and the departmental CEO can be separated and the minister not drawn into day-to day-operations is widely queried (Lane 2000:144 & 151; Laffin 1997:48; Loffler 1998:10). For example, Lane (2000:144) considers it is difficult to achieve a clear-cut distinction between politics and management. He asserts that when things go well, government stays at arm's length from an executive agency. On the other hand, when things go wrong, politicians find it very difficult to stay far away. In fact, in the view of Loffler (1998:10), once political goals in contracts are fixed, the only way in which politicians can influence outputs is by way of process management.

Giving the Treasurer an ownership role was an innovation in the ACT. Prior to the introduction of the PPM approach, the Treasurer had no involvement in the operational activities of the health portfolio. The Health Minister, as a line minister, performed ownership and purchasing roles in regard to the activities of DHCC. The separation of ownership and purchasing roles and their respective assignment to the Treasurer and the Health Minister was expected to provide greater role clarity, and (as discussed later) to assist in the performance management of DHCC. Central agencies in the ACT saw this role separation as necessary because of their concern that DHCC may focus too much on its purchaser role. This was a view that is consistent with comments by Scott [G] (2001:212) that under PPM-type approaches there is an inherent tendency for the purchaser interest to drive out the ownership interest. He also claims that when this occurs there is a consequential lack of interest by ministers in the capacity of a department to deliver outputs in the future.

In contrast to arguments supporting the need for a separate ownership role, the data in Chapter 5 showed that the impact of providing a separate ownership role for the Treasurer (in relation to the activities of the CEO of DHCC) was that it largely duplicated arrangements already in place and created role overlap. This was not an unexpected finding. Weeks and Anderson (1995:21) had proposed that under the PPM approach in the health area in the ACT both the ownership and purchaser roles should rest with the Health Minister. Furthermore, Schick (1996:44) saw the solution to

the problem of the ownership role driving out the purchasing role as ‘more detailed specification of ownership issues in performance agreements.’ In this regard, the CEO of DHCC already had a performance agreement. So any concern by central agencies about strengthening the ownership role as part of the implementation of public service delivery policy could have been achieved by modifying the performance agreement.

The Purchaser and Providers

In the period prior to the use of the PPM, role separation was not a major feature of administrative arrangements in DHCC. However, TCH (the government hospital provider) operated with some degree of independence from DHCC. The separation of purchasing and providing roles in regard to government service provision activity was expected to clarify these roles. However, the data in Chapter 5 showed that the major problem resulting from the separation of purchaser and provider roles stemmed from the legislative arrangements that were put in place as part of the configuration of role and role relationships. These arrangements gave the (ACTHCCS) Board a potential role that was more like that of a line department (such as DHCC) than that of a statutory provider. The resulting confusion and conflict over the appropriate roles of the Board and DHCC and their relationship with one another hindered rather than assisted the implementation of public policy. Consequently, the arrangements put in place were a major example of an inappropriate configuration of roles and role relationships that had an adverse impact on the implementation of public policy and evidence of the crucial part that the administrative architecture played in the implementation of public policy.

Not only did the establishment of the (ACTHCCS) Board as part the separation of the purchaser and provider roles result in conflict with DHCC, it was also seen in clinical circles as providing another layer of bureaucracy in relation to the activities of TCH, and providing duplication of administrative services. Also, as noted in Chapter 5 and discussed in more detail in Appendix D, there was a concern that the administrative architecture that was developed resulted in a lack of ongoing clinical representation on the Board, and a perception that the arrangements excluded clinicians from a

key role in the decision-making process. The failure to provide an adequate role for clinicians as part of the configuration of role and role relationships was seen as detrimental to the formation of good health policy, and provided a significant catalyst for the abolition of the PPM (Reid 2002:6).

Government Providers and Ministers

Under role separation arrangements associated with the PPM approach, government providers had relationships with the Treasurer and the Health Minister as part of a configuration of role and role relationships designed to provide role clarity. However, the arrangements put in place did not assist the implementation of public policy by providing greater role clarity. As the data in Chapter 5 showed first, as part of ownership arrangements, government providers were able to develop a relationship with Treasury. Second the role the Health Minister was given (under the ACT *Health and Community Care Services Act 1996*), allowed direct relationship to be developed between the Health Minister and government providers. While the autonomy provided by the relationship between government providers is specifically elaborated on next, the consequences of these relationships were unnecessary tensions: between DHCC and Treasury over concerns about their relative responsibilities; and between DHCC and government providers, because the arrangements were seen by DHCC as giving providers opportunities to undermine arrangements in purchase agreements and its policy role.

Government Provider Autonomy

One of the consequences of role separation used was that they gave providers an opportunity to have greater autonomy. More autonomy for providers is related to the concept of “let the manager manage” and is often considered central to NPM-type approaches (Clarke & Newman 1997:56; Pollitt 1993:3). Moreover, it is based on the assumption that organisations work better if their lower echelons are given more discretion (Peters & Pierre 2000:12-13). However, as the data in Chapter 5 showed, the configuration of role and role relationships that was put in place when the PPM was introduced gave government providers much greater autonomy than was expected:

- the ACTHCCS was given a potential role somewhat akin to a government department; and
- government providers had direct access to the Health Minister and Treasury.

While provider autonomy was important, the configuration of role and role relationships that was developed to do this hindered rather than assisted the implementation of public policy for reasons that have been already discussed earlier in this Chapter. Overall the analysis indicates that where autonomous provider roles need to be developed, this should occur within a configuration of role and role relationships that does not compromise other roles and role relationships, otherwise the administrative architecture that is developed is very likely to have an adverse impact on the implementation of public policy.

Enhanced Role for Consumers

An enhanced role for consumers was one of the major expectations of NPM-type reforms such as the PPM (Peters & Pierre 2000; Scott [G] 2001:68). The configuration of role and role relationships that was developed as part of PPM arrangements for the health sector in the ACT was expected to provide an enhanced role for consumers by:

- placing DHCC and providers at arm's length to avoid provider capture; and
- DHCC operating as a proxy consumer.

The separation of the purchaser and provider roles is designed to address the issue of provider capture by weakening the influence of providers over service specification, and to strengthen the possibility that service design reflects user rather than provider needs (Knapp et al. 1994:133). However, the data in Chapter 5 showed that there was no evidence that provider capture was a serious problem in the health area in the ACT, prior to the use of the PPM. Even if there had been some evidence of capture, Boston et al. (1996:88) claim that concerns about provider (and bureaucratic) capture are exaggerated and that the view that institutional separation is the best way to reduce capture is open to doubt. Boston et al. (1996:94) argue 'that organisational designers need to avoid becoming fixated with the issue of provider capture, or with seeing functional separation as an automatic remedy.'

In addition to a lack of capture, the data in Chapter 5 showed that, operating at arm's length from providers meant that, on one hand, DHCC had reduced day-to-day contact with consumers, and was reliant on providers to undertake actions to give consumers a greater role. For example, DHCC often relied on major providers such as TCH, ACTCC and Calvary to get consumers more involved in service provision arrangements and to undertake consumer satisfaction surveys. Scott [G] (2001:90) noted that role separation arrangements in New Zealand had not been as successful in areas where the government retained a strong interest in the provider organisation. Moreover, Schick (1996:75) asserts that where the government owns an authority and obtains non-contestable outputs there appears to be little benefit in keeping purchasers and providers at arm's length.

Operating at arm's length was also one of the factors that made it difficult for DHCC to undertake a proxy consumer role. As noted above the use of arm's length separation resulted in DHCC relying more on providers. Also the idea that purchasers (indirect consumers) have the interests of consumers at heart and know what consumer's interests are has been questioned, especially in relation to the provision of community care (Hoyes & Means 1997:295). Moreover, the use of a proxy consumer role ignored the fact that providers (and especially non-government providers) often perform an important advocacy role on behalf of consumers, with some non-government organisations having advocacy as their major role. A role that is seen as important, not only for providers in the health sector (Bateman 2000:37-43), but also for a wide range of providers, referred to in the implementation literature as "street level bureaucrats" (Lipsky 1980:72).

Overall the analysis indicted that the use of arm's length separation and giving the purchaser a proxy consumer role as part of the configuration of role and relationships was of little benefit in achieving the policy goal of enhancing the role of consumers:

- there was no evidence of provider capture;
- arm's length separation hindered the proxy consumer role as it made DHCC more rather than less dependent on providers; and
- such arrangements ignore the advocacy role of providers.

Furthermore, the data in Chapter 5 showed that the major health consumer organisation in the ACT was not impressed by the attempts made to enhance the role of health consumers under the PPM in the ACT. This was not unexpected, for at a more general level Street (1994:373) expressed the view that, while purchaser/provider separation was supposed to allow consumers a greater role in the health care system, there was nothing in the system that would guarantee this. Also, Ferlie et al. (1996:192) found that evidence from the UK did not suggest that PPM-type approaches had given the consumer greater direct influence or control in the health area. Indeed, the dominant position of the medical profession over consumers appeared to remain largely intact.

RESOURCE ALLOCATION

The data in Chapter 6 and comments in the literature in Chapter 2 were drawn on to address the research question:

- How appropriate were the resource allocation arrangements that were developed as part of the PPM approach?

To address this question consideration was given to the appropriateness of the following major means (and goals that underpin them) used to develop resource allocation arrangements:

- specification of purchase requirements as outputs in contracts;
- purchase of services that focused on consumer needs; and
- procurement of services using contestable purchasing arrangements.

Purchase Requirements as Outputs in Contracts

The use of contracts and contracting out are major features of NPM approaches to service procurement, such as the PPM approach (Lane 2000:10). In contracts the purchase interest of government in outputs is related to concerns about quantity, quality, and cost/price (Scott [G] 2001:17), and so it is necessary for purchasers to have reliable information about these attributes of outputs in relation to planned contractual levels (Ovretveit 1995:133). In particular, from a resource allocation perspective, output quantities need to be costed or priced (Bennett & Ferlie 1996:51; Lane 2000:154; Mulholland & McAlister 1997:23; Scott 1996:31).

In the PPM used in the health sector the data in Chapter 6 showed that the specification of purchase requirements as outputs in contracts was designed to ensure that only those outputs necessary to achieve the government's desired outcomes were purchased, and that agreed outputs were specified in a transparent form. However, the data also showed that the costing of output quantities in contracts often presented problems for the provision of hospital services as the result of the lack of robust data, with the consequence that the contract negotiation process became unduly protracted, because of disagreements over price and volume. In addition, the expected benefits from using Diagnosis Related Groups (DRG) as a form of output costing fell short of expectations both because of the atypical nature of ACT hospitals, and because (as a form of output costing) DRG faced considerable opposition from clinicians who, *inter alia*, saw them as being too easy to fudge.

The provision of hospital services was not the only area where costing issues presented problems in contracts. In contracts between ACTCC and DHCC, costing arrangements were not related to the cost of individual outputs; they took a program costing form. Furthermore, the costing of services purchased from non-government providers presented particular problems, because the outputs purchased were often specified in terms of activities such as "occasions of service", where an occasion of service could be an appointment, visit, or an incoming phone call. In addition, the price paid was often somewhat arbitrary, and in many cases represented a contribution toward the cost of the organisations operations, rather than a price. Such problems were not unique to the health system in the ACT. At the time the PPM was introduced into the ACT, Walsh (1995:206) noted that the failure to develop internal pricing systems was a feature of the National Health Service in the UK. Also, difficulties in specifying purchase requirements in terms of outputs and prices were seen as a common problem in the community health sector (Hoyes & Means 1997:298).

Overall, the analysis showed that while the use of outputs in contracts as part of resource allocation arrangements for service purchasing had considerable appeal, there were often difficulties in specifying the outputs to be purchased

in terms of cost/price, quantity and quality in contracts, because of the lack of robust data. Besides, the lack of robust data resulted in disagreement over quantities and price that protracted contractual negotiations. Consequently, the use of outputs in contracts as part of resource allocation arrangements provided only limited assistance in implementing the PPM resource allocation goal of constraining costs. The use of outputs in contracts to specify purchase requirements would have been more appropriate and provided much greater assistance in the implementation of public policy if robust cost and quality measures were available.

Purchase of Services that Focused on Consumer Needs

As noted in Chapter 6, focusing on consumer needs involved issues associated with both determining and meeting consumer needs. Ovretveit (1995:108) expresses the view that it is difficult and inappropriate to detach assessing needs from meeting needs and sees these activities as part of a continuum. However despite this, from a resource allocation perspective there were financial and other constraints on both assessing and meeting consumer needs as part of the PPM approach, because:

- the needs of the wider community had to be taken into account;
- budgetary constraints limited the extent to which both needs were assessed and met; and
- non-price rationing measures were used to equate supply (the resources made available) with demand (actual need).

Furthermore, the focus on consumer needs is constrained because the purchaser of services is not only a proxy consumer but also a proxy citizen, so in situations where the wants of consumers are at odds with the wants of citizens, the latter's wants usually take priority (Alford 2002:344). Consequently, the focus on consumer needs (that was undertaken as part of resource allocation arrangements associated with the provision of health services in the ACT) provided only limited assistance in the implementation of the PPM resource allocation policy goal of adequately addressing consumer needs.

In more detail, the literature and the thesis data showed that health was an area where assessing and meeting needs presented difficulties that were not easily addressed by a PPM approach. While as noted earlier, Ovretveit

(1995:108) sees assessing and meeting consumer needs as a continuum, for the purpose of this further analysis the issues have been considered separately.

In assessing consumer needs Eagar (2000:3) expresses the view that there is no really systematic way to define health care standards and establish who is entitled to what level of health care. Also, Ovretveit (1995:108) argues that in relation to health, there will never be a full picture, as information concerning needs will always be partial and disputable and as Kerley and Starr (2000:190) assert, consultation is time consuming and a luxury not always available to the policy maker. The data in Chapter 6 showed that in general, interviewees considered that the process of determining consumer needs left much to be desired. To do the job well was seen as requiring far more resources than the government was prepared to commit.

In meeting consumer needs, market based approaches such as the PPM were underpinned by the use of price as a means of equating supply with demand, as Ellwood (1996:38) notes markets required a price mechanism. However, for services such as public health, where funding is generally provided by a third party and the product is free at the point of service, there are no price signals to influence the level of demand (Ross et al. 1999:23), so it is necessary to use non-price rationing (Turner 1995:165 & 192). However, Duckett (2000:158) sees political difficulties in introducing formalised rationing strategies in the public health area, especially when this approach appears contrary to the values of the general public. Therefore, in the public health area, it is claimed that rationing usually occurs through the 'medium of professional judgment or other forms of collective priority setting' (Vidler & Clarke 2005:34).

Public health is also seen as an area where clinical autonomy is used as a politically unobtrusive means of rationing health, and where clinical convention, with an overriding concern for the individual patient/client irrespective of the cost-effectiveness of treatments, tends to prevail (Eagar 2000:3; Harrison 1999:63). In the health sector in the ACT, the data in Chapter 6 showed that there were well established guidelines for rationing hospital services that usually involved some form of queuing. However, this was

often not the case for community services, for the provision of these services rationing arrangements were largely left to providers without, what they saw as, adequate guidelines for developing a framework for rationing services.

Contestable Purchasing Arrangements

The use of contestable purchasing arrangements was part of the administrative architectural design that aimed to assist in the achievement of the public policy goal of constraining the growth of health care costs. As noted in Chapter 6, two main ways of achieving contestability were through competition and benchmarking.

Competition

While competition was an important element of market based approaches, the academic literature indicated that the public health system in the ACT was unlikely to be an appropriate environment to use competition as part of resource allocation arrangements. At a general level it is argued that problems arise in using competition if:

- there are a small number of buyers and sellers;
- the price mechanism is poorly developed;
- cosy relations exist between dominant purchasers and dominant providers; and
- where cost, quantity and quality information available to purchasers is deficient (Blanchard et al. 1998:501; Means et al. 1994:177; Howden-Chapman & Ashton 1994:75).

More specifically in relation to health, Peters (1999a:279) argues that while encouraging competition in the medical-care industry is appealing as a solution to many problems, there are important differences between it and other industries, that reduce the utility of competition as a remedy. As Ellwood (1996:12 & 164) argues, healthcare markets, where there is intensive government intervention, are unlikely to have the features of a competitive market.

Data in Chapter 6 showed that DHCC had serious reservations about the benefits of using competition as part of the administrative architecture that formed part of the PPM approach, and used it sparingly. In purchasing hospital services, DHCC maintained its pre-PPM role delineation approach

which was designed to rationalise the provision of hospital services and encourage cooperation. However there was one instance where some elective surgery was put out to tender, largely at the request of the Health Minster, but as the data showed, DHCC ran into difficulties because of:

- the failure to take into account clinical priorities;
- the policies of health insurers; and
- the difficulties in getting private hospitals to undertake a competitive role.

In contrast to hospital related services, the increased number of providers offered greater potential for competition for the purchase of community care and mental health services by DHCC. However, as the data in Chapter 6 showed, competition for such services was limited to those funded with new money in conjunction with a set of guidelines that further constrained competition, resulting in very few of such services purchased by DHCC being subject to competition. In addition, as a result of concerns by non-government providers about the impact of competition on provider relationships, over the PPM period there was an increasing emphasis by DHCC on the policy of cooperation and partnership between DHCC and non-government providers. This was not an unexpected development as even in the UK (before the PPM was introduced into the ACT) the provision of a more competitive role for non-government not-for-profit providers of community services was seen as potentially having adverse effects on relationships, with competition for contracts having the capacity to strain or destroy mutual support networks built up over many years (Knapp et al. 1994:139).

Benchmarking

The increased use of benchmarking was expected to be a feature of the use of the PPM, to provide a basis for demonstrating cost effectiveness by benchmarking ACT hospital services against those elsewhere. Also, it was hoped that community services would be able to be compared against national benchmarks. The data in Chapter 6 showed that the use of benchmarking especially in regard to hospital services was the cause of considerable disagreement. There were concerns that CGC figures were not designed to be used as a form of benchmarking. Also, despite the potential offered by DRG for hospital services, the benchmarking of ACT hospital costs

against those elsewhere was seen to be of limited value and widely questioned as often not comparing like with like because of the atypical nature of the level and scope of the services provided in the ACT. Moreover, appropriate benchmarking arrangements for community services were never developed.

It was not surprising that the use of benchmarking was of limited value as part of the administrative architecture designed to assist the implementation of public policy. In the literature it is argued that benchmarking techniques which are common in the private sector can be difficult to apply in the public sector (Walsh 1995:93). Furthermore, it is claimed that benchmarking: requires a rigorous methodology; ownership by those affected; and comparison of like with like. It is also asserted that unless prior agreement is reached in regard to the methods to be used benchmarking can result in endless arguments (Scott [G} 2001 182-183; Waters et al. 2001:60).

Overview

While reliance on contestability was an important part of the administrative architecture associated with market type approaches, the literature shows that competition was subject to a number of general reservations and seen as having serious limitations in the health sector where there was a strong emphasis on cooperation. Therefore, it was not surprising that competition was largely seen as inappropriate and used sparingly as part of resource allocation arrangements by DHCC. Moreover, the decision to rely on other means, to assist in the implementation of the public policy goal of restraining costs, shows the crucial part played by the administrative architecture in implementing public policy.

While benchmarking offered an alternative to the use of competition, the analysis highlighted the difficulties in not only using benchmarking in atypical constituencies, but also the general difficulties in using benchmarking for public service delivery.

PERFORMANCE MANAGEMENT

In this segment of the Chapter, the data in Chapter 7 and comments in the literature in Chapter 2 were drawn on to address the research question:

- How appropriate was the performance management framework that was developed as part of the PPM approach?

To address this research question, consideration was given to the appropriateness of the following major means (and goals that underpin them) used in relation to a performance management framework:

- separation of ownership and purchasing objectives;
- use contracts to specify objectives;
- specification of performance in output terms;
- use of a managerial accountability approach; and.
- use of meaningful performance measurement.

Separation of Ownership and Purchasing Objectives

The separation of ownership and purchasing objectives was expected to contribute to greater performance objective clarity. However, as noted earlier the separation of ownership and purchasing roles seem to have provided no useful purpose. Therefore, it was also unnecessary to have separate ownership and purchasing objectives as part of the performance management framework, especially when this involved spreading these responsibilities between the Treasury and Health portfolios. This view is supported by the fact that the division between ownership and purchasing objectives is seen as being somewhat artificial especially where there are dominant public providers (Lane 2000:219). Moreover, Ahmed (2001:2) argues that, where the interests of the owner are related to managing the asset and resource mix to deliver high quality outputs at least cost, they converge with the purchaser's interests.

Contracts as a Performance Management Tool

Management by contract involves a move away from the use of hierarchical authority to control at arm's length (Bennett & Ferlie 1996:51-53; Boston & Pallot 1997:384; Lane 2000:152 & 179; Walsh 1995:136). Lane (2000:219) notes that in NPM approaches (such as the PPM) contracting replaces

authority as a means of performance management. Also, as a means of performance management, contracting is often seen as providing a basis for making responsibilities explicit, and as superior to coordination in getting the job done (Lane 2000:152 & 154; Parsons 1995:331; Hancock 1999:59; Walsh 1995:112). Furthermore, contracts are seen as heightening questions about supply and costs (Lane 2000:154: Walsh 1995:112).

Contracts between DHCC and providers were expected to provide a transparent basis for performance management by setting out the agreed:

- broad policies and principles underpinning the purchasing arrangements;
- outputs and outcomes to be achieved;
- performance measures that were to be used; and
- reporting arrangements that were required.

The data in Chapter 7 showed that contracts did provide the opportunity for greater transparency. For example, contracts between DHCC and providers included the:

- policies and objectives of the ACT Government and DHCC; and
- agreed outputs to be purchased, performance measures, and reporting arrangements.

Besides, the contractual negotiating process allowed DHCC to gain a better understanding of what providers did and in addition to adopt a much more structured approach to the performance management of services supplied by non-government providers. This resulted in these providers becoming more business-like and having to pay more attention to their performance.

Despite the advantages discussed above, traditional contracts which were used as part of the PPM approach are subject to a number of limitations, which affect their appropriateness as a performance management tool. Framing contracts is difficult and they are never complete (Callon 1998:255; Domberger 1998:61; Walsh 1997:37). In addition, Lane (2000:153) asserts that in a contractual situation, ‘the actual outcome arrived at will reflect the bargaining strength of the parties involved.’ The case study data showed that while contracts between DHCC and providers ostensibly contained an agreed position, providers often saw DHCC taking a dominant position in contract negotiations because DHCC was often the only purchaser of the services they

supplied. As a result, from a performance management perspective contracts were often seen by providers as one-sided, containing onerous provisions, and having an adverse impact on their flexibility.

Concern about the shortcomings of the traditional contractual arrangements that were used was not limited to providers. In the view of Lane (2000:194) NPM-type contracts are often not enforceable in a legal sense. The data in Chapter 7 showed that DHCC was concerned about the impact of the autonomy of providers on its capacity to enforce contracts. Government providers had direct access to the Health Minister which provided them with an opportunity to circumvent contractual arrangements. Also, non-government providers often had agendas that were not aligned with DHCC. This is not atypical, for as Walsh et al. (1997:34) assert contracting parties often either do not observe or contradict what is in the contract in what they do.

Overall, the analysis suggests that because of the distrust and the adverse impact associated with the use of traditional contract arrangements as part of the performance management framework under the PPM approach, it would have been more appropriate to use a form of relational contracting as part of the administrative architecture to assist the implementation of public policy. In the view of Walsh et al. (1997:34-35), contracts are often more to do with relationships than with what is exchanged, so where there is a need for a high degree of trust and cooperation, contracts need to be both socially as well as technically appropriate. Also, the limitations of using traditional contracts are seen as being very noticeable in areas where human services are involved (Domberger 1998:165).

Specifying Performance in Output Terms

The specification of performance in output terms was part of a performance management move away from a focus on inputs. The focus on outputs occurred because public sector requirements were seen as being notoriously difficult to specify, and outcomes difficult to measure and open to debate and political contention (Domberger 1998:162; Kettl 1997:450-451; Scott [G]

2001:193; Spearritt 1997:33). Scott [G] (2001:193) asserts that a more concrete specification than outcomes is generally needed for the guidance of departments and that outputs serve this purpose. However he warns that the use of poor output specification engenders poor performance (Scott [G] (2001:178).

From the perspective of DHCC, the focus on outputs as part of the performance management framework gave it a better understanding of what providers did. This was something that was often lacking in the pre-PPM period. Moreover, the specification of performance in output terms made non-government organisations look at their performance, which led to a greater clarification of what workers did. The data in Chapter 7 showed that the use of outputs to specify performance objectives was often not easy and the results often unsatisfactory. As noted earlier in this Chapter, there were major difficulties in specifying output performance in meaningful terms of quantity, quality and cost/price. Even DRG, which offered great potential as an output measure, did not live up to expectations. In addition, there was a lack of support for the outputs approach in the health sector. For example, one interviewee claimed that the concept of “outputs” was an industrial one, of questionable relevance to human services.

Not only did outputs need to be specified in meaningful terms to be appropriate, they also needed to have some relationship to outcomes. Kettl (1997:451) sees output measurement as the building block of performance measurement systems as ‘there can be no assessment of outcomes without first gauging outputs.’ Scott [G] (2001:192-195) claims that while outcomes need to be linked to the government’s desired outcomes, the relationship between outcomes and outputs in many policies is not clear. Moreover, it is noted that health is an area where there is often a considerable lag between an intervention or treatment and an outcome (McMurray 1999:69; Palmer & Short 2000:104). As a result, achieving outputs gives no indication of outcome achievement. Besides the data in Chapter 7 showed that providers were particularly concerned that the use of outputs did not give a good indication of the outcomes they were trying to achieve or what was being delivered. In addition there was a concern that activities became output

driven at the expense of outcomes, and that a focus on numbers did not show that health had improved.

Overall, the analysis showed that while there were some benefits in using outputs from a performance management perspective, as noted earlier the lack of robust measures limited the effectiveness of outputs as part of the performance management framework and their usefulness in assisting the implementation of public policy. Also as noted in the literature, the relationship between outputs and outcomes is not always clear. Also achieving outputs gives no indication of outcome achievement.

Managerial Accountability Approach

The major expected outcome from the use of a managerial accountability approach was greater accountability for results by providers. Under the PPM approach used in the health area in the ACT, managerial accountability arrangements involved both the health and treasury portfolios. The arrangements were somewhat complex. Government and non-government providers were accountable for meeting the contractual arrangements agreed with DHCC. In addition, government providers were accountable to the:

- Treasurer as part of ownership arrangements for the efficient and business-like use of their resources; and
- Health Minister under provisions of legislation relating to the ACTHCCS (although there were no formal arrangements in place).

The data in Chapter 7 showed that the impact of these multiple accountabilities was to create confusion. The data also showed that DHCC sought considerable information (especially from government providers) to meet both its managerial and political accountability needs. However, the data suggests that it was often not clear to providers why such information was being sought. This led to tension between DHCC and providers who appeared to see the information sought by DHCC as part of an attempt by DHCC to micromanage their activities and restrict the flexibility that should be associated with a managerial accountability approach concerned with accountability for results.

In the academic literature Hughes (2003:247) notes that even under managerial accountability approaches in the public service political accountability exists. Besides, in the view of Mulgan (2004:9-16) governments still retain ultimate accountability for all serviced provision and Ministers and public servants can not escape accountability for service quality. Therefore all service delivery agencies cannot avoid the political accountability process. However, there is a concern about political accountability being seriously compromised when public services are delivered by organisations that have a purely contractual relationship with government, and about the likely tensions between accountability to government and responsiveness to the market, with policy makers having to balance commercial pressures with social pressures, social needs and democratic expressions (Muetzelfeldt 1999:155; O'Faircheallaigh et al. 1999:70-71). Pierre and Peters (2000:196) warn that one of the main problems facing NPM-type approaches such as the PPM is defining a robust system of accountability and addressing the tremendous complexities in identifying who is responsible in a market-designed system of public service delivery.

The data and the literature also indicate that in sectors such as health, the concept of managerial accountability to purchasers cuts across conventional arrangements, in which clinical professionals see themselves as primarily accountability to patients. This was an issue that impacted on the effectiveness of the PPM approach in the health sector. As noted by Mulgan (2000:4-5) health is an area where professional accountability, involving accountability to peers, provides a basis for conflict with managerial accountability.

Overall it was clear from the analysis that the multiple accountabilities that involved the DHCC, the Health Minister and the Treasurer that formed part of the performance management framework hindered rather than assisted the implementation of public policy. The analysis also illustrated that the impact of professional and political accountability on the administrative architecture was not limited to the PPM used in the health sector in the ACT. In particular the analysis indicates that potential conflicts between managerial accountability and political and professional accountability requirements need

to be addressed when developing an administrative architecture for any market based approach to service delivery.

Meaningful Performance Measurement

The PPM approach was expected to provide a performance management framework with performance measures that had a clear purpose and accurately measured output delivery, and were meaningful in number. Pollitt and Bouckaert (2000:86) see performance measurement as a central feature of public management reform, with NPM type approaches focusing on outputs (Hughes 1994:69). In addition, deBruijn (2007:8) expresses the view that performance measurement creates transparency.

The data in Chapter 7 showed that under the PPM approach to the provision of health services in the ACT, performance measurement was approached from three major perspectives, those of the:

- ACT Government through the ACT Budget;
- Purchaser; and
- Owner.

For each output sub-class (e.g. Mental Health) in the ACT Budget there were separate performance measures that were categorised in terms of quantity, quality, timeliness, and cost, with a small number of selective measures for each category. It was an approach that became a form of categorising performance measures. Consequently, the extent to which ACT Budget performance measures assisted in the implementation of public policy was doubtful. For example, quantity measures were highly aggregated and not always meaningful, and the cost measure for each output sub-class was not related to any level of outputs. As deBruijn (2007:20) claims information “casts a veil” when it is highly aggregated and remote from its primary source, as were ACT Budget quantity performance indicators for services such as hospital services.

From the perspective of the purchaser, the data in Chapter 7 showed that DHCC collected a large amount of performance information, especially from

government providers. However, the collection of a large amount of information as part of the performance management framework lacked support in the literature. For example Hughes (2003:161) considers that performance measures need to be meaningful but parsimonious. Also, deBruijn (2007:39) claims that performance measurement systems can become bloated and lose their simplicity in the process he referred to as the "law of mushrooming."

Apart from being too numerous, the performance measures used as part of the performance framework used for the PPM often had a number of other limitations:

- their purpose was often not clear, resulting in the Board (of ACTHCCS) seeing this as evidence that DHCC was trying to micromanage the activities of government providers;
- accurate measurement of output delivery was difficult, uncertainty affected quantity measurement, and there was a concern that there was a focus on quantity at the expense of quality and qualitative measurement;
- there was a lack of appropriate measures to address issues of cost; and
- in the absence of specific quality measures it was necessary to rely on standards and quality assurance schemes.

Even where there were no major limitations and output performance targets were achieved, deBruijn (2007:4) warns that this does not tell us anything about the professionalism and/or quality of the performance and that an effort to reach output targets has the potential to harm professionalism and quality.

In the health sector professionalism, and especially quality are important. However, it is a sector where despite its importance quality is difficult to measure (Ovretveit 1995:160-161). The data in Chapter 7 showed that because of the difficulties in measuring quality, DHCC often had to rely on proxy quality measures such as standards and quality assurance schemes. While comment in Chapter 7 showed that such schemes were subject to limitations, both Ovretveit (1995:160-161) and Walsh et al. (1997:49) see benefits in the use of quality assurance systems that providers can demonstrate to purchasers. As Brunnson (1999:118) argues, it is often easier to use standards than to exercise control through directives and orders.

From the owner's perspective performance measure were set out in Statements of Intent. However, as DHCC was the dominant purchaser of services from the government providers (TCH and DHCC), the benefits of Treasury having separate performance measures to meet ownership requirements was minimal, especially as there were no real benefits in placing the purchasing and ownership roles in different portfolios. Furthermore, the data in Chapter 7 shows that most of the ownership performance measures for ACTCC were a subset of those in purchase agreements it had with DHCC. Also the diverse and poorly coordinated performance measures for TCH did not contribute to a performance management framework that assisted in the implementation of public policy.

Overall, the analysis showed that the performance measures that were developed as part of the performance management framework left much to be desired and any contribution they made to the implementation of public policy appeared to be more than offset by the confusion about their purpose and other limitations. Further performance measurement was constrained by the fact that health was an area where it was somewhat difficult to measure performance in a manner consistent with the PPM approach, and even as late as 2005, Smith (2005:219) expressed the view that health systems were still in the early days of performance measurement and there remained an enormous agenda to improve their effectiveness.

SUMMARY

There was ample evidence from the analysis of the research questions related to the components of the administrative architecture to conclude that the PPM arrangements that were used during the implementation process were not appropriate as an administrative architecture for the implementation of NPM-type public policy in the ACT health area designed to restrain the growth of ACT public health care costs. Also it was possible to conclude that the administrative architecture, (in terms of the components) played a critical part in the policy implementation process, because changes to the components (such as the configuration of role and role relationships) of the

administrative architecture were necessary if more effective implementation was to occur. The analysis also indicated that even at a more general level the administrative architecture through which a public policy is implemented plays a critical role in the implementation of that policy. Many of the reasons the administrative architecture was critical to the public policy being implementation in the case study were not confined to the health area in the ACT and were often equally applicable to the health sector generally or to other areas of public service delivery. The generalisability of the results is discussed in more detail in Chapter 9.

In regard to the specific research questions, first, the configuration of role and role relationships that formed part of the PPM approach did little to assist the implementation of public policy because in many instances they created unnecessary conflict and tension. The analysis showed that the role separation arrangements that were designed to have a major impact on relationships between:

- Politicians and Bureaucrats;
- The Purchaser and Providers; and
- Government Providers and Ministers.

However, these relationships were largely inappropriate, and in particular, the legislative arrangements put in place for the separation of the purchasing and providing roles of DHCC and ACTHCS were a major example of an inappropriate configuration of roles and role relationships that had an adverse impact on the implementation of public policy, and evidence of the crucial part that the administrative architecture played in the implementation of public policy.

The analysis showed that other arrangements that were inappropriate were those that gave government providers too much autonomy in regard to their relationship with Ministers, and those that were designed to enhance the role of consumers by placing DHCC and providers at arm’s length to avoid provider capture, and by DHCC operating as a proxy consumer.

Second, the analysis showed that the resource allocation arrangements that were developed were largely inappropriate and did little if anything to assist the implementation of the public policy goal of constraining costs. While the

use of outputs in contracts was conceptually appealing, the use of outputs was of little value when there was a lack of robust data to cost them. The use of outputs in contracts as part of the administrative architecture would have provided more appropriate assistance in restraining costs if more appropriate and accurate data were available.

While the use of contestability also formed a key part of the PPM approach to restraining costs, the analysis showed that the use of competition was considered by DHCC as less appropriate in most instances than the role delineation arrangements (and other arrangements, such as the program approach to funding) that existed in the period prior to the introduction of the PPM. In fact the decision to retain these pre-PPM arrangements as a major part of the administrative architecture provided another compelling example in the thesis of the crucial part played by the administrative architecture in policy implementation.

Focussing on consumer needs was also an important goal of the PPM resource allocation arrangements. However, the analysis shows that there were financial and other constraints on both assessing and meeting consumer needs:

- the purchaser was not only a proxy consumer but also a proxy citizen so the needs of the wider community had to be taken into account;
- budgetary constraints limited the extent to which both needs were assessed and met; and
- non-price rationing measures were needed to equate supply (the resources made available) with demand (actual need), however these measures were somewhat subjective with a lack of adequate guidelines for rationing community services.

Finally the analysis shows that in regard to the performance management framework:

- it would have been more appropriate to use a form of relational contracting as part of the administrative architecture to assist the implementation of public policy for the provision of human services such as health;
- the lack of robust measures limited their effectiveness as part of the performance management framework and their usefulness in assisting the implementation of public policy;

- the multiple accountabilities that involved the DHCC, the Health Minister and the Treasurer hindered rather than assisted the implementation of public policy;
- potential conflicts between managerial and political accountability requirements needed to be addressed when developing an administrative architecture for any market based approach to service delivery; and
- the performance measures that were developed as part of the performance management framework left much to be desired and any contribution they made to the implementation of public policy appeared to be more than offset by the confusion about their purpose, and other limitations.

The next Chapter sets out the thesis conclusions.

Chapter 9

Conclusions

The PPM approach introduced into the health area in the ACT in 1996 as part of NPM-type public sector reform arrangements, was seen by the ACT government as providing a recipe for solving major problems in the public health service delivery in the ACT, and in particular as a means of restraining the costs of that delivery. However, the thesis indicates that as an administrative architecture the PPM approach was largely a solution developed before the problems it was aimed to address were fully appreciated. It was based on an "off-the-shelf reform model" with some modifications that provided a new administrative architecture for the implementation of public policy for public health service delivery.

While as an administrative architecture the PPM did not assist the ACT Government to successfully implement its public health service delivery policy goal of restraining the growth of ACT public health care costs, there was ample evidence from the analysis in Chapter 8 to conclude that the administrative architecture played a crucial part in attempts to implement that policy. The remainder of this Chapter provides: arguments to support the generalisability of the findings in Chapter 8, and identifies generic types of situations that result in the development of an administrative architecture that does not assist the implementation of public policy; adverse implementation situations. Finally, a major lesson that can be drawn from the thesis is set out at the conclusion of the Chapter.

GENERALISABILITY OF RESULTS

The generalisability of the results of this thesis had the potential to be limited because it was based on a single case study. However, as Yin (2009:43-48) notes the generalisability of single case studies can be enhanced by:

- the extent to which the case is typical or representative; and
- analytical generalisation.

While this thesis relates to the representation of the PPM as an administrative architecture for the implementation of public policy in the health area in the ACT, there are important typical aspects of the case that reinforce claims that the results are generalisable. As illustrated in Chapter 2 the literature supports the view that many of the concerns raised during the study relate to typical problems in implementing public policy. For example, Weeks and Anderson (1995:6) assert that the approach to the use of the PPM in the ACT is a “classical” one. Also, the components of the administrative architecture (which are the embedded units of analysis) are generic and part of the administrative architecture for the delivery of any public services.

The generalisability of the results is also enhanced by fact that there are sufficient major examples of issues in the analysis in Chapter 8 where the literature shows that the findings have wider support and relevance especially in relation to the implementation policy related to public service delivery. For example there is support in the literature for findings related to issues concerning:

- role separation arrangements designed to avoid ministers being drawn into the day to day operations of a department;
- the provision of an enhanced role for consumers through arrangements that were designed to avoid provider capture, by placing purchasers and providers at arm’s length and constraining the advocacy role of providers;
- the measurement and costing of outputs;
- price and rationing matters in relation to assessing and meeting consumer needs;
- limitations of competition and benchmarking;
- the use of contracts as a performance management tool;
- the specification of performance in output terms;
- managerial and political accountability; and
- performance measurement.

While further research would help to confirm the findings in this thesis, as argued above the typical aspects of the case and the examples in the analysis provide strong support for the conclusion that the domain of the results can at least extend to the implementation of public service delivery.

ADVERSE IMPLEMENTATION SITUATIONS

In this thesis, the findings suggest that the administrative architecture will not assist the implementation of public policy in situations where:

- arrangements that are put in place as part of the administrative architecture are unnecessary and/or inappropriate; and
- the administrative architecture through which public policy is implemented is constrained by the means used.

Unnecessary and/or Inappropriate Arrangements

In the case study, there were a number of situations where the administrative architecture used was underpinned by principles that formed part of the PPM, but did not assist in the implementation of public policy because the arrangements that were developed to assist were neither necessary nor appropriate. This occurred because of a failure to take account of:

- the impact on pre-existing arrangements;
- the likely future arrangements that could result from the administrative architecture that was being put in place; and
- the appropriateness of alternate means.

Impact of Pre-Existing Arrangements

The major examples in the thesis of the failure to take account of the impact on pre-existing arrangements were the:

- decision to separate ownership and purchasing roles;
- failure to continue to involve clinical professionals in key decision making roles; and
- the use of competitive tendering for the provision of health services.

First, the decision to separate ownership and purchasing roles did not take account of the fact that the configuration of role and role relationship that existed prior to the use of the PPM approach in the ACT involved the separation of:

- the “line” portfolio responsibilities of the Health Minister and DHCC, which included both the purchasing and ownership roles; and
- the “whole of government” portfolio responsibilities of the Treasurer.

Under the PPM approach, government providers (TCH and ACTCC) became responsible to the Health Minister under the ACT *Health and Community Care Services Act 1996*. However, as statutory authorities under the ACT *Financial Management Act 1996,* they were also responsible to the

Treasurer. Under this latter legislation (as noted in Chapter 5) the formal role and responsibilities of the Treasurer went beyond that of an ownership interest. In fact the Treasurer had a role in relation to TCH and ACTCC that was somewhat akin to that of a line minister.

These arrangements failed to take into account the pre-existing line responsibilities of the Health Minister and DHCC. Consequently, rather than providing greater role clarity that assisted with the implementation of public policy, the role separation arrangements that were put in place resulted in:

- role overlap between the Health Minister and the Treasurer; and
- role conflict between DHCC and the Treasury.

In particular, the conflict between DHCC and Treasury was not surprising. Public health provision is one of the most politically sensitive areas of government activity and hence an area where the Health Minister was likely to be held partly (if not fully) accountable for adverse events. Furthermore, the practice in Australia, where there are line departments, was to limit the use of Statutory Authority arrangements to government business enterprises and “off-line” activities.

Second, as an administrative architecture the PPM approach had the impact of reducing the role of clinical professionals at TCH in what they saw as a key decision making process. As noted in Chapter 3, in the period prior to the PPM, clinical professionals had considerable involvement in the management of TCH which was administered by a 6-member committee comprising a general manager and senior hospital staff, and funded under program based arrangements. However, with the introduction of the PPM clinical professionals considered that they were excluded from the decision making process because there was no clinical representation from the hospital on the Board which was also far more remote from hospital management than in pre-PPM arrangements. Therefore by ignoring the pre-existing involvement of clinical professionals in the decision making process the administrative architecture that was developed was subject to an adverse reaction from the medical profession. In fact, concerns of the clinical professionals about their

lack of involvement in decision making were a significant reason for ending the PPM approach in 2002 (Reid 2002:6).

This example illustrated the need to ensure that adequate account was taken of the role played by, and concerns of, professionals when major changes were made to administrative architecture, otherwise they were likely to undermine the changes. These views are supported by the view of Alexander (2000:178) who sees clinicians and especially doctors as fundamental to the success of health reform as 'they can wield their power to expedite or derail reform.'

Third, competitive tendering arrangements were a key aspect of the PPM. However, as the data in Chapter 6 showed that during the PPM period the limited tendering that was used was only partly successful because, as the analysis in Chapter 8 showed, insufficient attention was given to:

- existing patient/specialist, and doctor/hospital relationships in the public hospital system;
- the policy of health insurers and the concern of doctors in regard to private hospitals tendering for public hospital work; and
- the existing level of cooperation between non-government providers.

Likely Future Arrangements

The thesis indicated that failure to take adequate account of the likely future consequences of the administrative architecture arrangements was very likely to result in an administrative architecture that hindered rather than assisted the implementation of public policy. The two major examples of this illustrated in the case study were:

- the legislation that gave the (ACTHCCS) a role somewhat similar to DHCC; and
- the level of autonomy given to government providers under PPM arrangements.

The legislation that established the ACTHCCS resulted in the development of a configuration of roles and role relationships without adequate consideration being given to the likely future consequences, resulting in conflict between DHCC and the Board over what their relative roles and relationships should be.

The level of autonomy given to government providers (TCH and ACTCC) under the administrative architecture associated with the PPM was such that they were able to obtain direct and ongoing access to the Treasury and the Health Minister. This gave them the potential to compromise the contractual arrangements they had with DHCC, and unduly undermine its policy role and control over the direction of health policy. Consequently, where autonomous provider roles are part of the administrative architecture, the thesis suggests that they should be developed within an administrative architecture that does not compromise other role and role relationships, otherwise there is likely to be an adverse impact in the implementation of public policy. However, as Christensen et al. (2007:154 & 160) warn there will always be a tension between autonomy and control, and 'it is difficult to have both at the same time, or to find a stable balance between the two.'

Alternate Means Considered Appropriate

The thesis showed that there were situations in which the administrative architecture that was actually used was not underpinned by principles that formed part of the PPM approach, because the means to be used as part of the PPM approach were considered to be inappropriate. In the case study there were three major examples where alternate means were used to those that formed part of the PPM. The types of means that were often replaced were:

- outputs to assist with purchasing arrangements;
- contestable procurement arrangements; and
- full-cost pricing for services purchased from non-government providers.

First, the ACT government ostensibly based the funding used to purchase health services on the cost/price of the outputs it desired to purchase. However, because of the difficulties in robustly costing/pricing outputs, the funding was often based on other means. For example:

- at the ACT Budget level the funding provided to purchase outputs was based on the funding provided in the previous year plus an allowance for inflation and new initiatives, rather that the aggregate cost of the outputs that were to be to be purchased; and
- The funding for services purchased from ACTCC were program rather than output related.

Second, under the PPM approach the use of contestable procurement arrangements as part of resource allocation arrangements was to be one of the major means of constraining costs. However, very limited use was made of competition as part of the PPM because in the main DHCC considered alternate arrangements more suitable. Such a decision was inline with comment by Peters (1999a:279) that there are important differences between the health sectors and other industries that reduce the usefulness of competition as a remedy.

Third, the use of the PPM approach involved services being purchased for a price. However in many instances DHCC continued its Pre-PPM approach, for services purchased from non-government providers, so the “price “ was in the form of a contribution towards the cost of the services provided. However this is not atypical, Rogan et al. (1997:59) assert that governments are reluctant to move away from a “contribution” model of funding non-government services because of the pressure it put on costs.

In the above three examples the data indicated that where decisions were made to use means that were not in line with the PPM design, pre-PPM arrangements were used as part of the administrative architecture. It was clear that the motivation for using these alternative means was that it would be more in line with the government policy objectives of restraining health care costs.

Constraints on the Administrative Architecture

In the thesis there were situations in which the administrative architecture was underpinned by principles that formed part of the PPM approach, but there were constraints on the effectiveness of the means that formed part of the administrative architecture. There were two major examples where the means used as part of the administrative architecture provided only limited assistance to the implementation of public policy, because of constraints on their usefulness. These were the use of:

- traditional contract arrangements; and
- the absence of robust output information.

While traditional contracts formed part of PPM, the analysis in Chapter 8 indicated that where health services were involved it was more appropriate to use relational contracts because they were better suited in situations where there was a need for trust, cooperation and flexibility. This finding was supported by the view of Domberger (1998:165) who noted that there were limitations in using traditional contracts where human services were involved, and suggested that precise performance specification and monitoring was difficult in these situations.

As the analysis also showed, the lack of robust output information had an adverse impact not only the specification of purchase requirements in terms of outputs as part of resource allocation arrangements but also on the effectiveness of the performance management framework. More generally both examples show that there is little benefit in having an administrative architecture that includes means that do not assist in the implementation of public policy.

CONCLUSION

Hughes (2003:68) expresses the view that it is not uncommon for NPM-type reforms to be instigated at the top, with insufficient attention paid to the implementation process. In addition, Peters (1999a:69) claims that governments often do not have a very good conception of the policy instruments they use. In this thesis it is argued that it is probably also true that governments do not have a good understanding of the crucial role and subsequent impact of the administrative architecture they use to implement public policy. Therefore a major lesson that can be drawn from the thesis findings is that care needs to be taken, when public management reforms are introduced in service delivery areas, to ensure that the means/instruments used as part of the administrative architecture are relevant to the problems that need to be addressed. Otherwise the successful implementation of public policy associated with the reforms is not assisted by the administrative architecture that is being developed or used. As Christensen et al. (2007:181) assert, when reforms are introduced into the public sector there is no alternative to making a thorough analysis of the challenges and identifying the main problems, as the point of departure should be the problem not the solution.

APPENDICES

Appendix A

SUPPLEMENT TO CHAPTER 2

This Appendix supplements Chapter 2 by providing an outline of approaches by Elmore (1982 &1985), Sabatier (1986), Goggin (1990), Matland (1985) and Winter (1990 & 2003b) to the synthesis of the top-down and bottom-up approaches to policy implementation that were referred to in that Chapter.

Elmore

Elmore (1982 & 1985) developed a forward and backward mapping approach. The forward-mapping component consisted of precisely stating policy objectives, elaborating detailed means-ends schemes, and specifying explicit outcome criteria by which to judge policy at each stage. Backward-mapping consisted of precisely stating the behaviour to be changed at the lowest level, describing a set of operations that could ensure that the change occurred, and repeating the procedure upwards by steps until the central level of policy implementation was reached (Matland 1995:150).

Elmore's approach was based on what he saw as the reciprocal nature of authority relations. In that regard he noted that:

> Formal authority travels from the top to bottom in organisations: the informal authority that derives from expertise, skill, and proximity to the essential tasks that an organization performs travels in the opposite direction. Delegated discretion is the way of capitalizing on this reciprocal relationship; responsibilities that require special expertise and proximity to a problem are pushed down in the organization, leaving more generalized responsibilities at the top. For purposes of implementation this means that formal authority, in the form of policy statements, is heavily dependent on specialised problem-solving capabilities farther down the chain of authority (Elmore 1982:23).

Sabatier

Sabatier (1986) addressed the differences in the top-down and bottom-up approaches by specifying the conditions where one approach may be more relevant than the other. He suggested that the top-down approach was best suited for studying implementation in policy areas that were dominated by

one specific piece of legislation, limited research funds, or where the situation was structured at least moderately well. In contrast, he suggested that the bottom-up approach was more suited to situations where there was no dominant piece of legislation but rather large numbers of actors with no power dependency, or where the primary interest was in the dynamics of different local situations (Sabatier 1986:37).

Goggin

Goggin et al. (1990) synthesised the top-down and bottom-up approaches into a communications model of intergovernmental policy implementation that placed state implementers at the nexus of a series of communication channels. In this approach, three clusters of variables that affect state implementation were seen as important: inducements from the federal level, inducements and constraints from the bottom, and state-specific factors defined as decisional outcomes and state capacity (Matland 1995:151). Under Goggin's approach, state level implementers receive policy messages from the national, state and local levels. National-level inducements and constraints were used to incorporate top-down influences. The approach, while putting the state at the nexus of communication in the federal system, puts the ultimate authority of the implementation process in the hands of the federal policy leadership. The bottom-up influences of state and local actors were represented in the model by state and local government inducements and constraints (Cline 2000:558).

Matland

In taking his approach, Matland (1995) suggested that top-downers and bottom-uppers tend to study different types of policies. In his view the level of conflict and the degree of ambiguity affected the implementation process in significant ways. Therefore, he developed a conflict-ambiguity matrix. In this matrix, a policy situation characterised by:

- low ambiguity and low conflict was referred to as administrative implementation and was seen as closely paralleling the traditional top down model;
- low ambiguity and high conflict was referred to as political implementation and was seen as more closely aligned with the newer top-down models;

- high ambiguity and low conflict was referred to as experimental implementation and was seen as more representative of a bottom-up than a top-down approach; and
- high ambiguity and high conflict, was referred to as symbolic implementation and neither the top-down or bottom up approaches were seen as entirely appropriate in describing this perspective.

Winter

Winter (1990) developed what he referred to as an "Integrated Implementation Model." In this model, rather than trying to directly synthesise the top-down and bottom-up approaches, he integrated into a joint model what he regarded as the most fruitful theoretical elements from various pieces of implementation research, regardless of their origin. The main factors used to explain implementation outputs and outcomes are 'policy formation and policy design, inter-organisational relations, street-level bureaucratic behaviour in addition to target group behavior, socio-economic conditions and feed-back mechanisms' (Winter 2003b:216).

While Winter (1990:36) acknowledged that his representation of the implementation process did not specify if and how the variables are related, he made a number of suggestions. In summary, he considered, first, that the behaviour of street-level bureaucrats was often affected by:

- their organisational setting and by inter-organisational relations;
- how resources have been mobilised; and
- the inter-organisational networks found in the implementation stage.

Second, Winter argued that street level bureaucrats rarely affect policymaking or revision processes, with the result that vital information about target group behaviour was usually absent from the policy making process. Third, he believed target group behaviour was affected by the coping strategies used by street-level bureaucrats to ration and hold back services; and that target attitudes could be reflected in inter-organisational networks through positions taken by interest groups.

Appendix B

SUPPLEMENT TO CHAPTER 3

This Appendix supplements Chapter 3 by providing details of:

- activities of the community division of DHCC and non-government providers in the pre-PPM period;
- non-government providers of mental health services to DHCC and their role in 1995-96 (Appendix Table B.1);
- Commonwealth Government funding arrangements for hospital services in the ACT: arrangements during the PPM period;
- WVH/TCH and Calvary funding arrangements prior to and during the PPM, and ACT hospital casemix funding arrangements; and
- health sector concerns about the introduction of reforms.

ACTIVITIES OF THE COMMUNITY DIVISION OF DHCC, AND NON-GOVERNMENT PROVIDERS IN THE PRE-PPM PERIOD

In the pre-PPM period the four main activities of the Community Division in DHCC were:

1. Primary health care teams based in health centres, women's health activities, dental health services, migrant health, and alcohol and drug services;
2. Community care through residential services for adults with disabilities, community access programs, aged and disability programs, community nursing, and a nursing home facility;
3. Policy, coordination and development services; and
4. Business support services (ACT Government 1995b:133).

The first two of these activities was administered by the Community Division through the following programs:

- Alcohol & Drug Service;
- Community Nursing;
- Dental Services;
- Primary Care Health Centres;
- Primary care other (health advancement services, women's health and aboriginal health);
- Grants (predominantly to non-government non-for- profit providers);
- Jindalee Nursing Home (Sold by tender March 1996);
- Aged – Home Care
  - Activities undertaken by the division's own staff, and non-government providers who received a grant; and
- Residential Services (for people with a disability) (ACT Government 1996d:4).

In addition, a range of community services were undertaken by non-government providers as part of activities and programs that included those

referred to as: health grants, pregnancy counselling, Medicare grants, national women's health program, community division grants, and aged and disability grants.

Appendix Table B.1

NON-GOVERNMENT PROVIDERS OF MENTAL HEALTH SERVICES TO DHCC AND THEIR ROLE: 1995-96

Organisation	Role funded by DHCC
Centacare (Ainslie Village)	Accommodation and Support
Experiencing Post and Ante Natal Depression (a)	Self help group for women with post natal depression
GROW	Self help group, with a residential rehabilitation program
Innana	Outreach, resources and information and group work shops for women with mental illness and or experiencing emotional trauma.
Mental Health Foundation	Mutual support, fundraising and lobbying group
Mental Health Resources (a)	Resource Centre and office for Mental Health Foundation, Schizophrenia Fellowship and Maniac Depressive Support Group
Post Natal Depression Support Group	Support, information and referral for women facing post-natal depression
Richmond Fellowship	Accommodation and Support
TRANSACT/Companion House	Advocacy, Counselling and Medical Services for people experiencing torture

Note (a) During the PPM period Experiencing Post and Ante Natal Depression was absorbed into the Post Natal Depression Support Group and Mental Health Resources was absorbed into the Mental Health Foundation.

Source: The Annual Report of DHCC for 1995-96:174-177; and the Report on Mental Health Services in the ACT 1996-97:24.

COMMONWEALTH GOVERNMENT FUNDING ARRANGEMENTS FOR HOSPITAL SERVICES IN THE ACT: PPM PERIOD ARRANGEMENTS

Commonwealth funding arrangements for hospital services in the ACT were covered by five year agreements between the Commonwealth and the ACT during the PPM period. The PPM began during the agreement covering the 1993-98 period. From July 1998 onwards, funding arrangements were covered by a Healthcare Agreement, between the Commonwealth and the ACT Governments. These agreements provided Commonwealth funding to the ACT for hospital services on the basis that Australian citizens were able

to access public hospital services as public patients, and funding to support specified hospital related activities such as the development and implementation of quality improvement and enhancement practices and national programs such as the casemix program. Commonwealth funding was provided to the ACT on weighted basis related to its population (Australian Health Care Agreement between the Commonwealth of Australia and the Australian Capital Territory 1998).

WVH/TCH AND CALVARY FUNDING PRIOR TO AND DURING THE PPM, AND ACT HOSPITAL CASEMIX FUNDING ARRANGEMENTS

WVH/TCH and Calvary Funding

Prior to the implementation of the PPM funding of hospital services was program based. At the ACT Budget level there was within the DHCC portfolio a separate program for Woden Valley Hospital with 9 sub-programs including mental health services and a range of hospital activities such as medical services, surgical services etc. Each sub-program was allocated a level of funding in the ACT Budget. (ACT Government 1995b:94-121). Calvary was a sub-program of a program titled 'Major Grantees' (ACT Government 1995b:127-128). With the implementation of the PPM, first, program budget arrangements were replaced at the ACT Budget level with funding by output classes and outputs. In the first year of the PPM resources allocated to Public Hospital Related Services were included under the output class 'Purchase of Health and Disability Services" (See Table 3.2 in Chapter 3). In 1997-98, hospital services became a separate output or output class. Also, because it was regarded as a separate government authority, the activities of TCH were separately budgeted for in Annual Budget Estimates: Separate revenue and expenses information was shown for TCH during the period of the PPM.

ACT Casemix Funding Arrangements

A casemix system of hospital funding is one designed to describe the mix and type of patients treated by a hospital. In other words it is designed to identify the pattern of a hospital's work load or throughput. (Picone & Hathaway 1998:87). There are a number of casemix classifications in

operation throughout the world which are designed to describe and fund hospital work by measuring the cost of providing episodes of care to categories of patients who are assumed to have similar medical problems and to require the use of roughly similar resources (Podger & Hagan 2000:125-126; Draper 1999:140; Picone & Hathaway 1998:87).

The best known casemix classification system (and the one that is used in the ACT and extensively elsewhere in Australia) is referred to as “Diagnosis Related Groups” (DRG). The DRG classification system is based on the principle that diagnosis and other patient characteristics can be categorised in terms of the quantity of resources used in treating patients. Therefore, an individual DRG is composed of types of patient care episodes that require similar types and quantities of hospital resources (Picone & Hathaway 1998:87).

As a form of hospital funding, the use of the DRG system allows hospitals to be paid on the basis of how many care episodes in each DRG a hospital either treats or is contracted to treat (Draper 1999:140; Picone & Hathaway 1998:87; Swerissen & Duckett 2002:24). In particular, the system allows a standard cost/price to be assigned to individual DRG based on case weights for care episodes. The average case weight is set at 1, and the costs of episodes of care are scaled accordingly. For example, an eyelid procedure could have a case weight of 0.74 while a much more complicated procedure could have a case weight of 5.5. Therefore, the total case weight of these two procedures is 6.24 rather than being counted as two procedures (DHCC 1997a:2).

In Australia, DRG arrangements for acute hospital care relate costs to a national standard, the Australian National-Diagnostic Related Groups (AN-DRG) (National Health Ministers’ Benchmarking Working Group 1996:95). Over the PPM period AN-DRG were modified and updated. At the start of the PPM, the standard used in the ACT was referred to as AN-DRG3 and the last two years of the PPM the standard used in the ACT was referred to as AN-DRG4.

Prior to the implementation of the PPM, the use of DRG in the ACT hospital system was limited to internal management purposes (personal

communication). However, with the implementation of the PPM, the use of a DRG related system became a major means of funding acute care services purchased by DHCC from TCH and Calvary. It was expected that this type of approach would, inter alia, promote 'allocative efficiency across competing priorities and benefits' (ACT Government 1996a: 85).

THE INTRODUCTION OF REFORMS: HEALTH SECTOR CONCERNS

When the health care reforms were introduced in the ACT there was a lot of apprehension about their likely impact based on the "bad press" that preceded their introduction into the ACT. For example, Degeling (1993:36) noted that many Australian hospital employees had interpreted the shift to a more managerially oriented and finance driven approach as a denial of the qualitative and social dimension of care provision, and saw the transformation of care into a commodity defined in terms of its costs as an attack on what they regard as the "moral" community of their hospital.

Furthermore, there were concerns about what had happened in New Zealand and Victoria. For example, in an address to a 1995 Australian Medical Association Industrial officers Conference in Canberra the Executive Director of the Association of Salaried Medical Specialists in New Zealand suggested that:

> If anyone in Australia is considering following the New Zealand model then my advice is to forget it. Failure is too kind a description. Basing a public health system on commercial competition is like splitting a fish and chip shop into two so that one sells fish and the other hot dogs, and then expecting them to compete against one another. All you get is a greasy mess (Powell 1995:16).

Also, during interviews a senior executive in DHCC expressed the view that the opposition of doctors in the ACT to the PPM approach were influenced by the reforms that occurred in Victoria following the election of the Kennett government in 1992. Even in regard to community care services in Victoria, Smith (1999: 178-180) observed that there had been concerns about:

- the adverse impact of output based funding and the splitting of purchasing and provider roles;
- the limitations of service contracting on provider flexibility; and
- the divisive nature of compulsory competitive tendering.

In the wider literature it was noted that while PPM-type approaches had strong support from central departments and in particular treasury officials (Ahmed 2001; Boston et al. 1996:263-264; Schwartz 1994:53-54; Scott et al. 1997:361), there was considerable resistance to the approach in health related areas both in Australia and overseas. This resistance was based on a number of concerns, including those about: purchasers usurping the role of professionals in determining patient need; the assumption of provider self interest; competition replacing co-operation; transaction and administrative costs outweighing its benefits and reducing funding for patient care; the focus on cost effectiveness leading to economic imperatives dominating; a lack of output flexibility; and market forms of performance management replacing direct government management arrangements that facilitated rational planning (Eagar et al.2001:46, Lewis et al. 1996:2 & 4; Ovretveit 1995:10 & 21; Smith 1999:179-180).

Appendix C

SUPPLEMENT TO CHAPTER 4

This chapter supplements Chapter 4 by providing details of:

COMMON INTERVIEW TOPICS NON-GOVERNMENT PROVIDERS (OTHER THAN CALVARY) OF COMMUNITY SERVICES (COMMUNITY CARE AND MENTAL HEALTH)

ROLE AND ROLE RELATIONSHIPS

1. The nature of the type of service(s) your organisation provides.

2. Use and role of volunteers.

3. Have relations with DHCC changed as a result of the use of the PPM, is there more or less autonomy (If respondent involved prior to July 1996)?

4. Any direct relationship with the Commonwealth.

RESOURCE ALLOCATION

1. The extent to which consumers have a say in the type, level and quality of services provided, and how are Consumer's needs provided?

2. Do any other organisations provide similar services?

3. Do you have to tender for the services you provide, if so, do you have to provide details of evidence to support the services you provide?

4. If you don't tender on what basis is your funding provided?

5. Can the services you provide be benchmarked?

6. Source of funds and reliance on DHCC Funding.

7. Funding of volunteer Services.

PERFORMANCE MANAGEMENT

1. What outputs do you produce and what outcomes are you expected to achieve?

2. Use of Contracts including the length of contracts, quantity price and quality issues and policy goals of DHCC.

3. How useful are contractual arrangements: what would you like to see them replaced with?

4. Monitoring of Services, reporting arrangements (Accreditation).

Appendix D

SUPPLEMENT TO CHAPTER 5

This Appendix supplements Chapter 5 by providing details of the:

- Responsibilities of Chief Executives of Departments under Section 31 of the ACT *Financial Management Act 1996; and*
- Role separation arrangements between DHCC and the (ACHCCS) Board.

RESPONSIBILITIES OF CHIEF EXECTIVES OF DEPARTMENTS Section 31 of the ACT Financial Management Act 1996

S31. (1) The responsible Chief Executive of a department shall be accountable to the responsible Minister of the department for the efficient and effective financial management of the department.

(2) The responsible Chief Executive of a department shall be responsible for ensuring –

(a) that the moneys spent by the department are within the appropriations made for the department;

(b) that the operations of the department during a financial year give financial result at the end of the year that is in accordance with the estimates contained in the budget papers for that year relating to the department;

(c) that the officers and employees of the department comply with the requirements of this Act and the financial management guidelines;

(d) that proper accounts and records are kept of the transactions and affairs of the department in accordance with generally accepted accounting practice;

(e) that adequate control is maintained over the assets of the department and assets in control of the department; and

(f) that adequate control is maintained over the incurring of liabilities by the department.

ROLE SEPARATION ARRANGEMENTS BETWEEN DHCC AND THE (ACTHCCS) BOARD

Initial Approach of the Board to its Role

It was noted by one Board member that during the early period of the PPM the Board adopted a low-key role. It operated largely as an administrative committee. A member of DHCC operated as secretary of the Board. In addition, in 1998 the CEO of DHCC began to attend the Board meetings as

an observer, and the Director of Finance and Management in DHCC became a member of the Board's Finance and Audit Committee. It was suggested by a senior executive in DHCC that this 1998 move followed a concern shared by DHCC and the Health Minister that there was a "them and us" approach developing between DHCC and the Board (interview comments).

Later Approach of Board to its Role

The approach by the Board to its role in implementing the PPM and its relationship with DHCC changed when the membership of the Board changed; there was greater interest in the need for the Board to comply with its legislated powers and responsibilities. An assessment was presented to the Board covering its broad legislated powers and responsibilities under its legislation. This led some Board members to be concerned that they had not been informed earlier by government officials about the full extent of the Board's powers. Consequently, in its provider role the Board moved to become more independent of the purchaser role of DHCC (interview comments: Board members).

As part of the move by the Board to become more independent of DHCC, the secretary of the Board was relocated from the DHCC to TCH – a move prompted, as one Board member stated, by a concern that the CEO of DHCC was vetting Board minutes prepared by the secretary. Also, an attempt was made to discontinue the practice of the CEO of DHCC attending Board meetings. It was felt that, in line with the intent of the PPM the Board in its provider role should operate at arm's length from DHCC in its purchaser role. There was a concern by the Board that the CEO of DHCC, and the DHCC representative on Audit Committee, were independently reporting back to the Minister on Board activities (interview comments: Board member).

The Board sought to have the CEO of DHCC excluded from Board meetings. Initially the Health Minister did not support this change and formalised the arrangement by a Direction under the power conferred upon him by the ACT *Health and Community Services Act 1996* (ACT Government 2000a:ii). Later, he changed his mind and stopped the practice of the CEO attending Board

meetings (interview comment: Health Minister). However, the Board did meet with the CEO of DHCC after Board meetings (interview comment: Board member).

In addition to becoming more independent of DHCC, the Board also moved to undertake activities, which it saw as part of its role. In this context, one of the functions the ACTHCCS was given under its legislation was:

> to make available to the public reports, information and advice on public health and the provision of health and community care services (ACT *Health and Community Care Services Act*, S 6(1)(h)).

For example, in early 2001, at a time when the Health Minister wanted to seek more ACT Government funding for TCH, he agreed to allow the Board to commission a study by the National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra (Waters et al. 2001) on ACT public hospital costs, rather than seek a report from DHCC (interview comment). A Board member suggested that this move added to the tension between the Board and DHCC, because DHCC wanted to control what would be looked at. Moreover, the Health Minister stated that DHCC hated the Board and saw it as a "pain in the bum" (interview comment).

Relative Roles of DHCC and the Board: Concerns

It was obvious from comments made during interviews that by 2001 there were serious concerns both by Board members and senior executives of DHCC about the relative roles of the Board and DHCC, and their relationship. Both saw a need for change.

During interviews, it was noted by one Board member that the CEO of DHCC never wanted a Board in its present format, and had his own option that involved a different structure. In addition, concerns expressed by Board members included views that the:

- way in which the various participants undertook their roles resulted in a PPM with inbuilt tension;
- relative roles of the Board and DHCC became a power issue;
- approach taken by DHCC intruded on the roles of the Board; and
- there was often conflict between the CEOs of the provider organisations and the CEO of DHCC.

To illustrate the extent of the concerns of the Board, one of its members supplied an undated discussion paper that was prepared for the Board in 2001. This paper included the following statements about the Board's role under the PPM approach:

> The legislation establishing the ACT Health and Community Care Service Board and Service allowed the Board to make a vital contribution to health service development, community consultation and planning. The Board has been restricted from performing this role by the Purchaser/Provider arrangements established at the same time, which relegated the Board the provider oversight role responsible only for specified funds and outputs.
>
> The funding and purchasing processes put in place by the Department have consumed enormous effort and time in purchase related activities. From the Board perspective it is a significant distraction from the purpose outlined in the legislation with limited discernible gains.
>
> The current operations of the funder/provider arrangements have:
> - created an environment of distrust -'them and us';
> - reduced collaboration amongst health and community care providers and fostered a secrecy and competitiveness which undermines good health planning;
> - made the Board's task of managing the finances and budgets of the Service entities much more difficult;
> - created substantial and unnecessary transaction costs; and
> - detracted from the development of strategic and public health planning.

In contrast to the Board, DHCC was concerned about the role the Board was trying to undertake. The wide role the Board tried to pursue was not anticipated when its legislative powers were developed. A senior executive of DHCC claimed that the wide role given to the ACTHCCS and its Board was a case of 'naive good intent' and the result of Government instructions during the drafting of the ACTHCCS legislation 'to broaden its role.' There was a concern by senior executives of DHCC about the governance and management roles that had developed under the PPM as the result of the role pursued by the Board. In particular, a senior executive of DHCC expressed concern about the usefulness of a Board with the roles and responsibilities it had been given (interview comments).

In the light of its concerns about the way in which role arrangements were operating, DHCC sought to develop alternate arrangements. In February 2001, DHCC distributed a draft paper, titled *Acute Health Services Plan: putting partnerships into practice,* for comment. It was widely distributed to

major stakeholders in the health system including the Chairman of the Board and the CEOs of TCH and ACTCC. This paper, which concentrated on the public-hospital-based aspects of the ACT health system, proposed a system of health and community care governance that involved the use of clinical streams that would be over-sighted by an ACT Clinical Council.

A senior executive of DHCC suggested that the purpose of the clinical streams approach was to try to allow clinicians to 'own where things are going.' In this context, during interviews clinicians expressed a number of concerns about the PPM approach. It was suggested that:

- the approach was dominated by accountants, there were too many layers of management, the key decision makers were not clinicians, and that the system of management was not designed around patients;
- it provided another layer of bureaucracy and unnecessary duplication of administrative services;
- there was a need for professional groupings to be aligned with administrative arrangements;
- there was no continuous clinical representation on the Board;
- the CEO and senior staff of DHCC were totally ignorant of the business of the hospital;
- the role of a hospital was to bring experts together to provide well organised care in an ambulatory setting in a multi-dimensional structure; and
- hospitals run on loyalty, goodwill, and co-operation.

The clinical streams approach was described as a form of matrix management in which money is spread across streams. The aim was to get people to work together. Even though the details of how the system would apply hadn't been worked out, it was suggested that there had been a lot of comment on the scheme which was a true system of consultation. It was argued that there was a need for arrangements that avoided endless battles. It was noted that Calvary did not have a Board and it was suggested that there was no reason why the CEO of the hospital couldn't report directly to the CEO of the Department, as did the then-CEO of ACT Housing (interview comment).

Appendix E

SUPPLEMENT TO CHAPTER 6

This Appendix supplements Chapter 6 by providing details of:

- schedules in contracts between DHCC and non-government providers,
- competitive tendering guidelines, and
- funding for mental health services in purchase agreements: ACTMHS, Calvary, and ngo's: 1996-97 to 2001-02, (Appendix Table E1).

SCHEDULES IN THE STANDARD CONTRACT BETWEEN DHCC AND NON-GOVERNMENT PROVIDERS

Schedule 1 Contract Details and further Definitions

Purchaser
Provider
Further Definitions

Schedule 2 The Services

The Services
Outcomes
Outputs
Performance Indicators
Performance Requirements
Quality Standards

Schedule 3 Requirements and Obligations of Provider

Assets Owned by the Purchaser
Assets Owned by the Provider
Assets not to be Purchased with the Purchase Price
Nominated Assets
Assets Register
Other Reports and Documents

Schedule 4 Purchase Price, Payment, Financial Requirements & Reporting

Purchase Price
Payments – in Arrears
Payments – in Advance
Financial Statements

Schedule 5 Performance Report

Schedule 6 Special Conditions

Insurance
AFP Checks – Recruitment of Employees and Volunteers.

COMPETITIVE TENDERING GUIDELINES

Competitive tendering was to be considered as the preferred approach when:

- a new program or service is established;
- there is a significant budgetary enhancement to an existing program;
- the service is regarded as a pilot project or a one off research or other development task;
- a supplier providing an existing service, which is deemed important to continue, is unable to continue providing that service to the satisfaction of the government;
- choosing a new supplier for an ongoing service, where an existing supplier does not wish to renew a contract (ACT Government 1999e:4).

Appendix Table E.1.

FUNDING FOR MENTAL HEALTH SERVICES IN PURCHASE AGREEMENTS: ACTMHS, CALVARY AND NGO's: 1996-97 to 2001-02

(Expressed in $ Terms)

YEAR	ACTMHS		Calvary (a)		NGOs (b)	Total
	Inpatient	Other	Inpatient	Other		
1996-97	4,977,671	9,474,259	2,058,400	79,887	875,739	17,465,956
1997-98	5,063,872	9,675,808	2,070,800	89,245	1,094,577	17,994 302
1998-99	5,778,546	9,023,885	2,325785	78,824	1,346,802	18,553,842
1999-00	6,028,000	9,208,256	2,619,354	60,922	1,819,833	19,736,365
2000-01	6, 027,957	10,653,632	2,094,672	594,387	2,513,610	21,884,258
2001-02	9,640,952 (c)	13,866,056	2,544,672	639,326	3,764,967	30,455,973

Notes: (a) In 1999-2000 there was an additional amount of $50,000 to cover ACT Factors, which is not included;
(b) estimated amounts paid to non-government service providers based on information in Annual Reports of DHCC for 1996-97 to 2001-02.
(c) includes $4.1 in 2001-02 to cover overheads at TCH.

Sources: Purchase Agreements between DHCC and TCH and DHCC and Calvary 1996-97 to 2001-2002, DHCC Annual Reports, 1996 97 to 2001-2002; and Reports on Mental Health Services in the ACT, for 1996-97 to 1998-99 (later issues not published).

Appendix F

GLOSSARY OF HEALTH RELATED TERMS

Acute Care Episode

An episode of care in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palatine care);
- reduce severity of illness;
- protect against exacerbation and/or complications of an illness and/or injury which could threaten life or normal functions;
- perform diagnostic or therapeutic procedures (National Health Minister's Benchmarking Working Group 19965:95).

Ambulatory – people not confined to bed.

Casemix
The several casemix classifications in operation throughout the world are designed to measure the cost of providing episodes of care to categories of patients who are assumed to have similar medical problems and to use roughly similar resources (Podger & Hagan 2000:125-126; Draper 1999:140; Picone & Hathaway 1998: 87). However the use of casemix in any payment system is dependent on the use of accurate cost data (Hickle 1994:S8).

Community Heath Services

In this thesis the term "community health services" includes community care and mental services provided in a non-hospital environment.

Cost Weighted Separations

A separation refers to the completion of an episode of inpatient hospital care. A cost weighted separation provides an indication of the level of resources consumed for each separation. A treatment with an average level of resource usage has a cost weight of 1 (Glossary in DHHCC 2001).

Diagnosis Related Groups (DRGs)

DRGs represent a class of episodes of care with similar clinical conditions, e.g. skin graft injuries to the hand. In the context of hospital funding it is principally a system of classifying and costing/pricing care episodes for patients. Patients with similar clinical conditions or diagnoses are assumed to consume similar amounts of resources. The system allows patient care

episodes to be classified into diagnoses related groupings, and a standard cost/price to be assigned to each grouping. Then hospitals can be paid on the basis of how many care episodes in each DRG a hospital either treats or is contracted to treat (Draper 1999:140; Picone & Hathaway 1998:87; Swerissen & Duckett 2002:24).

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Episodes of Care

An episode of care is a phase of treatment for an admitted patient. It may correspond to a patient's entire hospital stay or the hospital stay may be divided into separate episodes of care of different types, such as acute care, palliative care, and rehabilitative care (AIHW 1999:248).

Hospital Care

Hospital care is often referred to as acute care or clinical services. All these terms refer to hospital based treatment and care as there is no precise definition of acute care or clinical services.

Occupied bed days

The total number of days between admission and separation less any leave days (ACT Government 1998h:23).

Public Health

Publicly-funded health services (Baum 1998:510).

Separation

In a hospital sense the completion of an episode of inpatient care as the result of discharge, death, transferring to another hospital, or changing type of care (AIHW 1999:248).

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