

Driving Improved Value for Money in the New Zealand Public Sector

Introduction

The new, National-led government is seeking a significant lift in productivity and economic growth. Raising the performance of the public sector is central to achieving such an objective. In our view, improving public sector performance is unlikely if we rely solely on the management tools and approaches introduced some 20 years ago. Nor will periodic budget cuts and reductions in ‘back office’ resources result in the level of improvement desired (Cook and Hughes, 2009). Rather, the focus should be on how the public sector can stimulate innovation and economic transformation through its critical role as the leader of several large, pervasive value chains,² such as health, education, science, justice and social services.

The public sector reforms of the 1980s were an important catalyst for the revitalisation of the national economy at that time, in retrospect perhaps more because of the opportunity they generated to rethink longstanding practices and structures, than because of the qualities of the new public management model that was the central focus of the changes. With government expenditure accounting for 45%

of GDP, and few options for managing the huge increases anticipated in health, retirement provision and justice, the need for revitalisation is just as strong today as it was 25 years ago.

The aim of this paper is to highlight the potential for sustained increases in innovation and transformation of systems in the public sector through effective leadership of the most critical value chains, in health, education, science, justice and social services. Sustainable quality improvement and transformation requires innovation supported by insightful, informed leadership and far-sighted engineering of complex systems and processes. Significantly and sustainably improving value for money from the public sector will require redesigning large, sector-wide service delivery value chains from end to end, and making strategic shifts in the resource base, systems and mandate of organisations.

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Approach

The area of interest in this paper is government-owned organisations that deliver public services. This includes ministries and departments, the non-public service departments such as the New Zealand Police and New Zealand Defence forces, and Crown entities including the district health boards (DHBs).³ All public sector entities have a responsible minister, or, in a number of cases, multiple ministers.

At an institutional level oversight of these entities is provided by the 'central agencies', namely the Treasury, State Services Commission (SSC) and the Office of the Prime Minister and Cabinet (DPMC). The three central agencies work closely together, and initiatives to increase this cooperation have been expanded since the review of coordination among the central agencies in 2006. Outside of this arrangement, the Office of the Controller and Auditor General, as an officer of Parliament, plays an important role in addressing issues of accountability for value for money within the public sector.

Against this background, the question we have asked ourselves is why, with the institutional and governance structures in place, the high degree of short-term monitoring of public sector organisations by central agencies, and the analysis that takes place in the public policy agencies, are there such persistent difficulties in achieving high value-for-money public services? Our experience, from working in and with public sector entities, is that an important source of inefficiency is the inadequate attention given to leadership of the major public service value chains, and the oversight of that leadership. Poor leadership in service delivery value chains can dramatically reduce value for money, create resistance to systemic change that would bring productivity and quality improvements over time, and stifle the adoption of new opportunities for improvement in the quality and quantity of outputs.

In the complex sectors of health, justice, education and welfare, the value chains involve multiple organisations, yet we are not aware of any attempt to measure the degree of fragmentation in leadership in public service value chains, or the quality of leadership over them. For example, oversight and leadership of the network of parties which make up the public health value chain does not appear to be recognised within the governance roles and structure of the public health sector. We have only the proxy measure of New Zealand's poor record in increasing productivity (The Treasury, 2005).

Overall, it is New Zealand's place in the world that is vital to us, and in comparative terms we continue to slip (The Treasury, 2008). This most vital benchmark of our position in the world highlights the consequences of poor productivity, but gives little diagnostic indication.

Without insightful and effective leadership of the large value chains involved in the delivery of some public services, fragmentation in leadership can result in variable service quality and increased costs. To illustrate this, we have considered two inputs to the public health value chain;⁴ one is an example of integrated leadership and the other of uncoordinated and devolved, fragmented leadership. The procurement of pharmaceuticals is provided as an example of a streamlined system with effective leadership across this part of the value chain, while the training of the medical workforce is used as the example of a highly fragmented approach, which has been subject to considerable attention at ministerial level since 2007 because of this, with strong value chain leadership finally being proposed only recently.

We believe that the findings of this analysis reflect issues with value chain leadership or its absence across the New Zealand public sector. Along with observations from other fields, these findings are also proposed as a basis from which to formulate a strategic approach to driving value-for-money improvements from public services.

Medical workforce training: a highly fragmented approach

The training of the medical workforce in New Zealand follows a widely adopted model in which graduates trained at recognised universities progress through prescribed training programmes to gain registration with the industry body, the Medical Council of New Zealand. Vocationally-trained medical specialists including general practitioners are employed as senior medical officers (SMOs) primarily in DHBs, the providers of hospital services, and in providing health services funded through the DHBs, for example in general practice. In addition to New Zealand-trained SMOs and general practitioners (GPs), an important source of SMOs is from overseas, and these people make up for the undersupply of medical graduates from New Zealand universities who remain in the New Zealand workforce. In 2008, 6,446 doctors and doctors in training were New Zealand medical school graduates and 4,106 were overseas medical school graduates (Medical Council of New Zealand, 2009).

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Centralising the evaluation and purchase of medicines has enabled the development of specialist competencies, which arguably could not be maintained by DHBs evaluating and purchasing medicines individually.

Of the total expenditure of \$15.4 billion on health care in 2006, 78% was through the public health system, with the balance being private expenditure (District Health Boards New Zealand, 2009). The public expenditure is delivered through 21 DHBs. DHBs in turn fund GPs to deliver some services. There is a remarkable range in size between the smallest DHB and the largest. The smallest, in terms of the number of SMOs and doctors in training, is the West Coast DHB with 30, and the largest is Auckland DHB with 1,079 (Medical Council of New Zealand, 2009). Whilst there is a well-established process in place for training medical staff, under the current institutional arrangements there is a significant discrepancy in the ability of different DHBs to participate in that process.

For example, in most fields of medicine there is no clear strategy for national or regional service delivery, apart from some specifically designated national services, often based in Auckland or another of the largest DHBs.⁵ Size matters in being able to develop and maintain a clinical speciality, making it very difficult, even impossible for some DHBs to maintain the critical mass of staff necessary to satisfactorily undertake clinical services. In particular, they struggle to sustain training positions at registrar level, with follow-on implications for the recruitment at SMO level. Even if more funding was available, the potential patient base for many medical conditions would be insufficient to prevent huge differences in the quality of care, when the relevance of experience of medical staff is taken into account. Apart from smaller DHBs in places where lifestyle benefits are well recognised (Nelson and Hawke's Bay), most stand-alone clinical services in small DHBs have a very high turnover of SMOs, with consequent effects on service availability, leadership capacity and innovation. While there are examples of adjacent DHBs establishing collaborative arrangements (Southland and Otago, the West Coast and Nelson, and the central region DHBs) there has been no capacity to systematically set out a strategy for regional service delivery in the long-term interest of providing relevant national public health service.

As previously noted, there is no role in the health system for strong leadership across the DHB network, yet the Medical Training Board (2009) reports huge shifts in the size and age mix of DHB populations which will place the viability of many services at risk if they continue to be operated separately on a DHB specific basis. A recent commission appointed by the director-general of health also highlighted this concern in its recommendations.⁶

Many critical decisions about the health workforce have been made without relevant information. It is only recently that in-depth information about doctors in training has

been made available (by the Medical Training Board and District Health Boards New Zealand) in a form which might be used to develop informed approaches to more effectively managing the training of one of the country's most critical professional workforces. This is at a time when New Zealand will be doubling the number of medical graduates and without managed training there is a high risk of losing more of this highly mobile group.

Protecting the conditions under which doctors in training work has been a longstanding concern, and what goodwill existed in the past was severely undermined by poorly managed employment relations during the 1990s, characterised by the imposition of managerialism which undervalued clinical operational knowledge. As a consequence of this loss of goodwill, employment arrangements for doctors in training have become more highly formalised. The breakdown in trust has expanded the content of industrial agreements, and similar trends are occurring for senior doctors. There are two industrial organisations representing doctors in the DHB system, the New Zealand Resident Doctors Association and the Association of Salaried Medical Specialists.

A diversity of local management responses to a chronic national doctor shortage has led to the pay on temporary locum posts rising so much that a large number of doctors in training have opted for this and chosen to delay entry into vocational training. This has reduced the number of doctors in training in some areas below a critical mass to maintain the training in that speciality in a number of hospitals. SMOs have a similar degree of dissatisfaction, although the cause differs.

Over a lengthy period of significant budget surpluses, it has been politically less costly to maintain the status quo than to change how the medical training system operates. We now have a clear strategy to shift from a highly fragmented approach to the training of future SMOs. While the sector has, in areas, demonstrated a huge capacity to change, it is only recently that a decision has been taken to address the obvious problems with the medical training system.

Pharmaceutical Management Agency: a streamlined approach

In contrast to the fragmented approach to training doctors, the acquisition of drugs is a streamlined process, managed across the health sector value chain. The essential step in streamlining this process was the creation of the Pharmaceutical Management Agency, Pharmac. It was set up in 1993 as a joint venture company owned by the four regional health authorities for drug purchasing. Pharmac is now a Crown entity responsible to the minister of health, and has the twin tasks of making arrangements for access

to medicines and promoting the optimal use of medicines. It does this by managing the pharmaceutical budgets for the DHBs and evaluating which medicines should be funded by government. As the centralised pharmaceutical agency, Pharmac also assists DHBs to assess the cost effectiveness of new medicines. In 2009 the total expenditure on prescription drugs was \$635 million. Medicines are manufactured by private sector companies and a detailed understanding of the market for the supply of drugs is vital to being able to operate effectively as a purchasing agent.

Centralising the evaluation and purchase of medicines has enabled the development of specialist competencies, which arguably could not be maintained by DHBs evaluating and purchasing medicines individually. Coordinating the purchase of all medicines across the DHB network has also enabled the health sector to take advantage of its size, using the combined purchasing power of the DHBs to reduce costs. Importantly, the streamlining of pharmaceutical purchasing has enabled Pharmac to take an active role in educating consumers in the use of some medicines, especially antibiotics. Pharmac is active at three points in the value chain: evaluation, purchasing and education about the use of medicines.

What does this tell us about institutional structure and value for money?

The processes for training medical staff and purchasing medicines are both complex, but markedly different approaches have been taken, with one fragmented and devolved and the other integrated, with centralised leadership. These two examples illustrate two different approaches to acquiring inputs; clearly there are a range of other approaches that could be taken to managing other aspects of the health sector value chain. What these examples highlight are the advantages of taking an integrated approach, not just to realising value for money but to facilitating stakeholder engagement, including, if relevant, public education and debate. This will not be possible without leadership and oversight across the major components of public sector value chains.

In summary, our analysis highlights that:

1 *There are complex service delivery value chains associated with many public services.* Fragmentation in complex value chains has negative performance ramifications for all involved in the delivery of public services. Fragmentation can result in a significant reduction in value to consumers and it is disempowering for those working in the sector because it is too difficult to make changes to the system. From the perspective of the entire value chain, fragmentation results

in: (1) diminished opportunities to build a critical mass of expertise, bringing not only inertia but also building barriers to innovation and service delivery improvement; (2) forgone opportunities of economies of size and other means of gaining economic advantage; and (3) a larger burden of bureaucratic oversight obligations that come as expensive substitutes for standards and systems. Achieving sustained value for money from these public services will require leadership focused across an entire value chain (including the various inputs, transformation systems and outputs).

- 2 *These service delivery value chains are strongly dynamic, and imposing rigidities on them through fragmentation in value chain leadership has a significant impact on innovation, adaptability and dynamic efficiency.* There is a narrow and rigid approach to role and structure which is presented as a choice on a rigid continuum which ranges from government department to Crown agency through to SOE. Associated with this is an over-simplification of the market/public sector boundary which is seen as a preparedness for privatisation, this being indicated by where an entity is placed on this continuum. More signs of the excessive focus on institutional structures comes from the creation of artificial markets and fragmentation of value chains, sometimes as a consequence of the so-called funder/provider split, when one agency allocates the resources applied by other government entities at various stages of the value chain. A consequence of this excessive focus on institutional structures and of assigning the allocation of resources to agencies that do not have a deep understanding and leadership role across the value chains they fund is that the public sector has become detached from the reality of what is required to make New Zealand's public sector globally competitive. This detachment is manifested through excessive reliance on departmental outputs as a central indicator of performance, without regard for markets or systems, nor even the appropriateness of the end services delivered by public sector value chains. The creation of fictional markets to support atomised contestability, and relationships focused on financial contracts and compliance obligations, has reduced the ability of entities to respond to changing circumstances.
- 3 *Current institutional structures, legal authorities and budget delegations do not facilitate, and in some cases prohibit, the effective value chain leadership necessary to bring about sustained improvements in value for money in the provision of public services.* Value chain leadership requires clear acknowledgement

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There is no independent commentator on the value for money from public services.

that one authority has the mandate to gather information and engage in establishing a systems-wide view of the sector that they are part of. How this mandate is allocated and overseen may well need to be unique to the sector, as will the partners engaged in this work. Given the depth of concern about public sector performance, in the context of policy failings about productivity in the wider economy, delays in obtaining such a mandate should not prevent leadership initiatives within the public sector itself. We would also comment that, in our view, the policy/operations split has contributed to the current state of affairs. With the policy/operations split there has been a massive loss of information and increase in ignorance about the nature, direction and ongoing operation of our major public sector value chains.

4 *To lift service quality and improve value for money, it is certain that in any complex sector there will be some key standards or systems and it will be essential to have the mechanisms to oblige all institutions within a particular public sector system to adopt them.* The breadth and scale of internal production by formerly large government departments was extensive, but value chain leadership (or managing co-production) was simply not recognised before or after 1988 as an activity vital to dynamic and allocative efficiency that would add value, drive productivity gains and stimulate innovation. Even worse was the failure to identify anywhere the increased significance of effective value chain leadership in capitalising on the rise of global and national services and infrastructure. In New Zealand, 97% of GPs have electronic patient records and the capability to electronically deliver diagnostic information (compared to 25% of GPs in the USA), and yet the public health system has failed to put in place a common New Zealand-wide patient management system, or even common capacity for readily obtaining and exchanging diagnostic information, such as x-rays, across all centres. Concepts of core competencies and critical mass have slipped by unnoticed by the central agencies in New Zealand. The functional organisational form and contractual focus of the New Zealand reforms of the 1980s provided no vehicle, informal or otherwise, for ensuring common approaches to matters where an integrated approach across government entities could offer economies of scope or scale or efficiency gains.

There are also spill-over effects on other sectors. For example, those working outside the public sector are often required to emulate the bureaucratic processes of the public sector. The voluntary sector,⁷ for example, has experienced two decades of working with higher compliance costs brought about by extensively detailed but poorly evaluated contracts.

The result has been that the sector itself has increasingly loaded more administrative demands onto its front-line workers by centralising minor decision making and imposing additional compliance obligations. This has reduced for some the spontaneity and community service elements of voluntary work.

An inflexible attitude on the part of public sector entities which advances their own, and not sector-wide, objectives also engenders a high degree of caution amongst potential collaborators on the public/private/voluntary sector boundary. The uncertainty that this type of caution engenders makes it difficult for the private and voluntary sectors to justify investment to build new capacity (both human and physical). This reduces participation by the private and voluntary sectors and shifts the burden for new investment onto the public sector. The impact of this over time is for the public sector to reduce the strength of other potential collaborators in the delivery of public services.

The current structure of the New Zealand public sector does not provide authority to any entity or body to make governance decisions at a sector level, and, importantly, to lead implementation of those decisions, despite it being at this cross-sector level that leadership is most necessary if we are to make serious gains in lifting value for money and service quality.

At the political management level, the ministerial portfolio mix in New Zealand is almost always scattered, poorly linked and unable to provide a concerted focus on the delivery of outcomes. The capacity that ministers have to reach agreement becomes absolutely critical when there is no serious consideration given to how decisions within related ministerial portfolios should be aligned. This system is highly dependent on ministerial competence and predilections. Ministers have increasingly become active project sponsors, without the consequent expense of accepting the breadth of governance relevant to the significance of their decisions. All of this narrows the interest and capacity to focus on sector-wide issues, where success is likely to enhance the performance of your successor and being accountable for large-scale developments with high-risk profiles brings career risks, especially if the trust needed in public sector leaders is still developing. Compounding this is the political dimension to value-perception by ministers, which is driven by considerations of their own understanding of and position on issues, and political advantage.

The Fiscal Responsibility Act 1994 introduced disciplined procedures for the governance of government appropriations, set out in the annual government budget. No equivalent exists for the specification and monitoring of government outcomes. This absence of a nationally-agreed outcome strategy has had a number of ramifications:

Ministers as purchase agents do not necessarily recognise the less tangible accountability of each chief executive to be prepared for future governments or emerging problems.

There is a growing tendency for senior leaders in the public sector to be working in isolated and autonomous roles, and sometimes possibly advocating that they be given responsibility for sector leadership.

There is no independent commentator on the value for money from public services. The Treasury and SSC may have the mandate but, as part of the public sector, they are not independent parties. The Office of the Controller and Auditor General will investigate specific instances where authorities and procedures have not been adhered to.

To begin to redress this will require highly-informed central agencies, more effective understanding of systems and value chains by policy agencies, and much richer and more challenging interrelationships among all parties involved. The strong collaboration we now see among the central agencies may perversely strengthen tacit acceptance of the continued relevance of the approach adopted to public sector reform in the 1980s. Indeed, intense central agency collaboration and interdependence may well diminish contestability and challenge within these bodies.

A new set of rules

The managing-for-outcomes framework could have been a valuable achievement. However, current governance structures focus on chief executive accountability for the delivery of individual agency outputs in the absence of an accountability framework for sector-level outcomes and value chain leadership.

To address these shortcomings we have identified in this article will require:

- 1 Broadening governance structures and practices to encompass sector-wide solutions to outcomes. This requires both rethinking the performance management framework to give weight to value chain efficiency, and an entirely different and demanding approach to assessing outcomes.
- 2 Simplifying the major public sector service delivery value chains, centralising functions where appropriate, and continually striving to improve value for money in the delivery of outcomes. This requires identifying the key public service value chains and putting in place the means for their active leadership and oversight.
- 3 Changing public sector culture and incentives to work in alliances with other organisations in the private and voluntary sectors. This requires the active management of boundaries, which may see more work outsourced. More effective sector-wide leadership could result from

refocusing roles in the public sector institutional structure, without major structural change. This could be achieved by, first, establishing accountability for the delivery of a national agenda of outcomes – this is one of the two new roles we are proposing. We envisage that there could be between five and ten national outcomes established by government, covering the whole of the public sector, each with a set of supporting goals and performance indicators. Each national outcome would have an outcome leader with responsibility for working with key players to define the most appropriate service delivery value chain, set of players and role for each player.

These value chains would consist of a mix of public sector entities and private and voluntary sector entities. Operational responsibility for how the players work together would remain with the public sector delivery entity (for example, the DHBs and Pharmac).

The outcome leader would not be the chief executive of one of the delivery entities but would be a specially appointed role. Administratively, outcome leaders could be located within DPMC, but would take their mandate from the responsible minister.

Coordination of outcomes and management of the contribution made by public sector entities would be provided by a national outcome forum. This forum would consist of the national outcome leaders and the heads of the SSC and Treasury.

The state services commissioner would chair the forum as head of the public service, an extension to the current role. An extension to the commissioner's role would be necessary to provide the mandate for a focus on performance at sector and not just individual chief executive and agency level, and to coordinate activities across public sector entities.

In assessing outcome performance, the responsible minister(s) would consider the contribution made by all players in the value chains. The strategy for the achievement of outcomes and the role of the participants in the sector value chain would be set out in an outcome transformation plan. The outcome leader would be tasked with facilitating the process of developing the outcome plan in collaboration with key players in the value chain and in consultation with stakeholders, including New Zealanders and service users.

To contribute effectively to the forum, the Treasury would need to broaden its capability to assess the value for money from value chains involved in the delivery of outcomes. The Treasury would need an understanding not only of outcome and output performance but also of the transformation systems and inputs for the major public sector value chains in health, education, science, justice and social services.

Whilst there is a well-established process in place for training medical staff, under the current institutional arrangements there is a significant discrepancy in the ability of different DHBs to participate in that process.

Collaborative network arrangements seek to capitalise on the limited capabilities available in New Zealand and in so doing gain economies, and allocate risk and capital to the parties best able to manage them.

We propose an additional new role be established, that of an independent national productivity commission. The purpose of this body would be to examine and make recommendations on the efficiency and effectiveness of the major public service delivery value chains.⁸ It would report to a responsible minister with whom its work plan would be agreed. The reports of the commission would be published.

Under this model there would be no change to the role of the controller and auditor general.

Discussion

This post-bureaucratic organisational form recognises the unique features of public sector entities as well as utilising private and voluntary organisations to deliver government outcomes. An important way in which this new form of organisation differs from that currently found in the New Zealand public service is the active management of the dynamic boundaries between the roles played by all participants in public service delivery. These boundaries are managed and facilitated by the public sector.

Improved analytical capabilities and information will be needed in order to realise benefits from transformation in the major service delivery value chains. The information needed is not only related to organisational performance but also covers activities which constitute the service delivery value chain and its participants, the nature of input and output markets, and insights into how these markets might evolve. External evaluations with a sector-wide focus can play a vital role in challenging the status quo and counterbalancing short-term agency-level output measures which are used to assess public sector performance.

Changes of the type we describe would also put an end in many cases to the split between policy and operations, see consolidated processes in some cases, require improved governance arrangements and spell an end to the artificial competition that has been part of the justification for the fragmentation of sectors, most noticeably the public health sector. The funder/provider splits also need to be revisited.

Interestingly, the use of purchase advisors by the current National-led government could be seen as the embryonic development of the formal role of outcome leaders we are proposing.

There are also numerous examples from New Zealand of the use of commissions and boards to provide advice on specific matters: for example, electricity, telecommunications, retirement, film and medical training. Over the period 1977 to 1991 an advisory body, the New Zealand Planning Council, operated with a cross-sector mandate to advise government on economic, social and cultural planning. In

July 2009 a productivity taskforce was appointed to identify how New Zealand can close the income gap with Australia by 2025. Other taskforces have also been appointed to look at improving productivity in specific sectors, such as the Building and Construction Sector Productivity Taskforce established in 2008.

Summary and conclusion

The public sector has long been recognised as operating in a network with other organisations, including those in the private and voluntary sectors. The public sector reforms of the 1980s clarified the outputs that were to be delivered by public sector institutions, and privatised many government-owned and -managed activities. In this article we have put forward the proposition that the poor performance of the public sector is a result of widespread and systemic fragmentation in leadership of key value chains which support the provision of public services in complex sectors of government. We argue that streamlining sector-wide value chains will address recognised deficiencies in the current arrangements and drive improvements in value for money in the delivery of public services. We also argue that operating within collaborative network structures is more appropriate for a small, open economy, like New Zealand's.

Making greater use of networks and collaborative arrangements would require no fundamental changes in the legislative framework within which the public sector operates. Simple institutional structures need to be put in place to provide the governance to drive the adoption of practices for continuous improvement and value-for-money gains. We have advocated that this could be achieved through the creation of two new bodies and honing the roles of the SSC and Treasury. The new bodies are the national outcome forum to provide leadership in lifting value for money from public services, and an independent national productivity commission for monitoring the actual gains achieved.

Collaborative network arrangements seek to capitalise on the limited capabilities available in New Zealand and in so doing gain economies, and allocate risk and capital to the parties best able to manage them. An example of the economic gains that can be realised from taking an integrated approach to managing across a major public sector value chain was provided by the centralised drug-buying activities of Pharmac. In a country of four million people facing severe economic conditions, there are few justifications for the public sector not pushing hard to gain the full benefits from better exploitation of the limited capabilities available.

Despite what seem to us clear benefits from operating within a more systematic network structure, we would

caution that unless these structures are part of a redesign of the entire service delivery value chain with appropriate governance structures, the high costs of coordination and monitoring may make networks unworkable.

Addressing issues of governance, critical mass, leverage of assets and core nationwide systems, and an informed collective view of the future context, are seen as central elements of public sector leadership which will be critical to improving the value for money realised from public services in New Zealand. Addressing these issues will provide important tests of all policies and programmes, including decisions by ministers and central agencies. Unless these issues are addressed then the plethora of old and new approaches we will undoubtedly see brought to bear on the public sector will have little more effect than as rallying calls for change.

Most critically, the central agencies who are accountable for the public sector management system need to show how we are moving from the solutions of the past, given that our economic position has so painfully continued to

decline under their stewardship. This matters because the performance of the public sector is inextricably tied to New Zealand's future.

References

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- 1 We are grateful to Jonathan Boston, James Olson, Colin Lynch and an anonymous referee for their helpful comments. We would especially like to thank Megan Bray for her assistance.
 - 2 A value chain is a network of capabilities which culminate in the capacity to deliver goods and services.
 - 3 These agencies cover the departments listed in schedule 1 of the State Sector Act 1989 (the ministries and departments), the executive branch non-public service departments such as Police and Defence, and the district health boards (DHBs), which are listed in the first schedule of the New Zealand Public Health and Disability Act 2000. In addition there are agencies listed on the 4th schedule of the Public Finance Act 1989 and in schedules 1 and 2 of the Crown Entities Act 2004.
 - 4 Our concern in this article is with the negative impacts that high fragmentation in the entire service delivery value chain can have on the value for money and quality of public services. Our comments should not be taken as implying that we are necessarily arguing for larger institutions. Decisions of the most appropriate size of institutions would need individual analysis.
 - 5 The plastic surgery team at Hutt DHB is a clinical unit in a speciality where there is some national leadership from a smaller DHB.
 - 6 Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards 2009.
 - 7 Report of L.W. Cook et al. for ANGOA (the Association of Non-governmental Organisations of Aotearoa).
 - 8 Whether these services are undertaken by a newly-created entity or purchased from other providers is not considered here.