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Introduction

This report is devoted to matters concerning public entities operating in the health sector. The Audit Office is the auditor of a large number of such entities – including the Health Funding Authority and its subsidiaries, and 23 Hospital and Health Service companies and their subsidiaries.

Much of the public funding for the health sector is disbursed through contracts between the Health Funding Authority and providers of health services – such as the Hospital and Health Service companies. A small number of those contracts are contestably allocated and, sometimes, the way in which the contract is perceived to have been let results in a complaint being made to us.

Report Content

The first article (on pages 9-45) concerns a Hospital and Health Service company – in this case Capital Coast Health Limited – and is about contracting for and implementing a new computerised information system. We looked into both aspects at the request of the Health Committee of the House and because of adverse comment in the media and elsewhere.

The second and third articles (on pages 47-66 and 67-83, respectively) concern contracts entered into by the Health Funding Authority for the provision of specialised services. Both contracts were subject to a contestable process for selecting the preferred provider, and both processes brought complaints to us on the grounds of claimed lack of fairness.

The fourth article (on pages 85-92) reports the results of a follow-up review of a subject that we reported on in 1997.[1] That subject was the payment of claims for subsidies for pharmaceutical services that are processed by Health Benefits

1 *Fourth Report for 1997*, parliamentary paper B.29[97d], pages 61-75.

Limited – a wholly owned subsidiary of the Health Funding Authority. The follow-up review looked specifically at what had been done to settle pharmacists' queries on the more than 10,000 unpaid claims for subsidy that we found in 1997.

Future Report Topics

We intend to continue looking at contracting for spending in the health sector. Next for our attention are primary health care services – such as fundholding arrangements for General Practitioners.

At present we are working on three matters for future reports to the House:

- The proposed change from a manual to an electronic system of processing claims for pharmaceutical service subsidies. The project involves the Health Funding Authority and its two subsidiaries – Health Benefits Limited and Pharmaceutical Management Agency Limited (Pharmac).
- Purchasing practices of Hospital and Health Service companies – with particular attention on major capital purchases, including buildings and information technology projects.
- A further review of the financial condition of Hospital and Health Service companies. We presented reports on their financial condition in 1997[2] and 1998[3]. This time the results should reflect the policy changes made in 1998 that were designed to improve their financial condition and financial performance.

2 *First Report for 1997*, parliamentary paper B.29[97a], pages 121-140.

3 *Second Report for 1998*, parliamentary paper B.29[98b], pages 11-36.

Contents

Summary

In 1996 and 1997, Capital Coast Health Limited (CCH) selected and contracted to purchase a comprehensive computerised information system from a supplier based in the United States of America – Shared Medical Systems Corporation (SMS).

Mr Jack Jenkins was appointed Acting Executive Chairman of CCH in November 1996. Dr Leo Mercer became the Chief Executive Officer of CCH in April 1997.

For a number of reasons, the way in which CCH came to select and purchase, and was implementing, the SMS system was the subject of adverse comment in the media and elsewhere. Because of the public interest in having the matter independently scrutinised, in May 1999 we decided to review all relevant aspects of the selection, purchase and implementation of the SMS system.

In summary, our conclusions are that:

- CCH complied with its policies and procedures in force at the time for the purchase of a major IT system.
- CCH handled the selection and purchase in an acceptable manner and followed good practice – although some aspects of the process could have been better handled.
- Generally, CCH's project management in implementing the system so far has been competent – although, again, there have been some minor process deficiencies.
- Implementation of the new system has been reasonably successful. The cost has been within budget, and only minor slippage has occurred against implementation timelines.
- Nothing that came to our attention suggests that either Dr Mercer or Mr Jenkins had any conflict of interest in the selection and purchase of the SMS system.

- We are in some doubt that, in committing CCH to purchase the SMS system, Mr Jenkins had the express and unequivocal authority of the CCH Board. The shareholding Ministers and their advisers were aware that Mr Jenkins intended CCH to purchase the SMS system, and we have been told that the CCH Board was similarly aware.
- We consider that CCH has made some significant achievements in delivering against the objectives established in 1994 to improve its information systems.

CCH needs to concentrate now on gaining maximum benefit from the investment in technology by:

- appointing a new project sponsor (to replace Dr Mercer) to restore the necessary degree of commitment and drive;
- establishing a planned approach to improving clinical ownership of the technology; and
- allocating resources to redesigning processes and procedures to make better use of the technology now available.

Introduction

Background

1.001 Capital Coast Health Limited (CCH) provides a wide range of health care services through Wellington and Kenepuru Hospitals – including emergency, maternity, radiology, and laboratory services, and inpatient care in surgical and general wards.

1.002 The computerised information systems (IT systems) that CCH inherited from the former Wellington Area Health Board in 1993 were in a poor state. The systems were old, not integrated, unreliable, and did not provide hospital management with the information needed for effective health care management. The ineffectiveness of the IT systems also meant that CCH was unable to record and cost its activities accurately, adversely affecting its ability to secure appropriate funding from the Health Funding Authority and its predecessors.

1.003 In November 1993 an Information Systems Steering Committee (ISSC) – comprising the Chief Executive Officer, all general managers, the chief financial officer, and the information systems manager – was formed to oversee and ensure that a structured approach was taken to address these issues. An Information Systems Strategic Plan (ISSP) was developed for the three years to 1997, the cornerstones of which were to "standardise, improve, and innovate" (where possible) in the respective years. This approach concentrated on existing systems, maintaining a balance between immediate demands of the business and longer-term goals.

1.004 Existing systems lacked interfaces between one another and suffered from poor supplier support. CCH's "vision" was for an integrated system based on an electronic medical record and documented care plans, with the prime focus being delivering and collecting clinical information as close as possible to the point of care.

1.005 In July 1995 the Board of CCH (the Board) created its own Information Systems Committee to provide high-level oversight and keep the Board informed of information system issues. The Committee approved a proposal to contract out the day-to-day management of IT systems and to seek a partner to advise CCH in achieving its longer-term goals of information system improvement and innovation. The ensuing tender process resulted in CCH contracting with EDS to provide those two services.

1.006 EDS identified a number of potential suppliers of health information systems who could deliver the solutions that CCH was seeking. After calling tenders Shared Medical Systems Corporation (SMS) was selected in October 1996 as the preferred supplier of the IT system to fulfil the CCH "vision", and contract negotiations began in November 1996. A contract for implementation of the SMS system was signed on 13 March 1997 and project-planning work began soon after.

1.007 In September 1997 "Project Iris" was started as an umbrella to carry out the separate projects to implement the six modules that were to make up the SMS system. The first module – Patient Registration and Accounting – was implemented during April and May 1998 and implementation of further modules is continuing. "Project Iris" is planned to be complete in June 2000.

Our Review

1.008 IT systems acquired by public sector entities have been the subject of considerable attention recently. CCH's acquisition of a system from SMS has given rise to adverse comment in the media and elsewhere about the way the system came to be selected and purchased, and whether it will be able to meet CCH's requirements. In addition, allegations have been made that some people involved in the selection and purchase had a conflict of interest.

1.009 The Health Committee of the House of Representatives was considering carrying out an inquiry into those matters. However, after we consulted with the Committee, and discussed the idea with the then chief executive of CCH (Dr Leo Mercer) who welcomed it, we decided to carry out our review.

History of the Project

1.010 In late-1993/early-1994 a group of CCH senior managers and clinicians attended a conference in the USA on the Transitions Clinical Costing System and visited a number of hospitals in the USA and Canada. The visits included the Sioux Falls Hospital in South Dakota where the CCH group observed an integrated information system based around:

- an electronic medical record;
- electronic ordering of clinical services; and
- documented, electronic clinical pathways (care plans);

which delivered and collected clinical information close to the point of care.

1.011 During 1994 CCH developed its Business Plan, which concentrated on upgrading hospital facilities. Funds were identified as being urgently needed for a building programme (replacement and refurbishment of hospital sites) and a programme to improve its information systems. The latter was driven by the "vision" described in paragraph 1.004. The ISSP was necessary to ensure that a structured approach was taken. Costs of achieving the "vision" were estimated at $26.2 million.

1.012 The ISSP was published in November 1994, following wide consultation among staff (including clinicians). The strategy of the ISSP to address the identified shortcomings in the existing systems was:

Year 1 – standardise existing systems and improve the IT infrastructure;

Year 2 – improve the performance of systems where possible; and

Year 3 – innovate by identifying and implementing clinical based systems.

1.013 In October 1995 the Community and Support Services department issued a request for proposals to meet its information system needs. A successful supplier – ANSO – was chosen and notified but, following the engagement of EDS (see paragraph 1.005), a second (modified) request was issued in February 1996 for a "Care Management System". ANSO and SMS responded. The project was not proceeded with.

1.014 In April 1996 EDS approached a number of providers of health information systems in the USA to identify any who might be interested in providing services in the New Zealand market. SMS and Cerner responded positively and were asked to demonstrate their respective systems.

1.015 EDS invited Dr Leo Mercer – at that time Associate Professor, Texas Tech University Health Service Centre, El Paso, Texas – to New Zealand to deliver a presentation on 6 May 1996 to CCH clinicians on the benefits of effective information systems. (Dr Mercer also gave the presentation at Middlemore Hospital in Auckland during the same visit.)

1.016 Based on his clinical background and considerable experience in the implementation of clinical information systems, Dr Mercer was considered an expert in the field. He had performed some consulting work for SMS in the USA and his name was used by SMS as a reference contact. CCH and EDS shared the costs of Dr Mercer's visit to New Zealand.

1.017 Also in May 1996 EDS recommended to CCH that the "vision" for its IT systems could best be delivered by implementing an integrated health information network (IHIN) – consisting of all health care applications available on a network to all users. The recognised options were to:

- identify and implement "best of breed" systems from multiple suppliers for each of the business areas; or
- define detailed specifications and develop systems from scratch; or
- select an "off the shelf" package solution from one supplier (which was considered a lower-risk option).

1.018 In accordance with the ISSP, CCH elected to proceed with the third option.

1.019 In May and June 1996 representatives of SMS and Cerner demonstrated their respective systems and conducted workshops for clinical staff. Based on the demonstrations and workshops, clinical and information systems staff (including EDS) evaluated what functions each of the available modules would deliver. The result was that the SMS system was considered marginally better than the Cerner product. A significant factor in the users' assessment was that SMS was able to demonstrate established modules, whereas some of the Cerner modules had yet to be developed.

1.020 Around the same time CCH initiated "Project Quantum". The purpose of this project was to establish a change management programme and process re-engineering to underpin the five strategic initiatives set out in the Business Plan, of which IT systems was one. Consultants were engaged to undertake the project at a cost to CCH of approximately $1.5 million. The ultimate result of the project was a conflict between re-engineering and new investment, and extreme difficulty in separating benefits that could be assigned to each approach. In both cases identified benefits exceeded $20 million. CCH management decided that re-engineering would be continued only for Mental Health and Surgical Admissions.

1.021 However, on 17 June 1996 CCH determined that it would be necessary to invite tenders for the supply of new IT systems. A request for proposals was issued on 12 July 1996.

1.022 On 15 July 1996 (two weeks before tenders closed) EDS indicated that it wished to submit a joint proposal with SMS. CCH wrote to EDS on 16 July voicing its concerns about the integrity of the selection process. This resulted in EDS withdrawing from its engagement to advise CCH (but not from its engagement to manage CCH's IT systems – see paragraph 1.005).

1.023 Given the potential for a conflict of interest – should EDS be involved in submitting a proposal – and the shortage of in-house information systems resources, CCH engaged other consultants (Deloitte & Touche Consulting, Working Knowledge, and Business Continuity Services) to help with the evaluation of proposals.

1.024 The joint EDS/SMS proposal was presented in a manner that did not permit clear comparison with the proposal submitted by Cerner. SMS then advised CCH that it was prepared to submit a proposal without the involvement of EDS. Following advice to all four suppliers that responded to the request (see paragraph 1.055), the request for proposals was reissued on 18 September 1996 to all the previous respondents except McDonnell Douglas Information Systems Pty Ltd (MDIS) – which decided not to bid a second time.

1.025 The proposals received were evaluated in late-September 1996. With the exception of the SMS bid, proposals were the same as those submitted the first time. The evaluation team recommended to the ISSC that SMS be the preferred supplier.

1.026 The General Manager Finance and Information Services – on behalf of the ISSC – prepared a paper for the Board meeting on 24 October 1996 stating that SMS was the preferred supplier and proposing further negotiations with the company. The paper also recommended that approval to proceed with further IT investment be withheld, pending the completion of the preliminary phase of "Project Quantum" (see paragraph 1.020) and resolution of CCH's fiscal problems. The Board did not discuss the paper – being preoccupied with its financial crisis – and the matter was held over until the next meeting.

1.027 In a memorandum of 7 November 1996 to Deborah Dickson-Freund of SMS, CCH's Chief Information Officer said that SMS had been recommended to the Board as the preferred supplier with which to proceed to the next stage of planning and negotiation. On 21 November 1996, the Board's Acting Executive Chairman (Mr Jack Jenkins) wrote to Ms Dickson-Freund undertaking *to initiate formal discussions to further define the business arrangements, and negotiate in good faith toward an agreement where the envisioned Integrated Health Information Network can be implemented.*

1.028 Dr Mercer arrived at CCH on 5 March 1997, from when he was involved in the final negotiations with SMS. The contract with SMS was signed on 13 March 1997 by Mr Jenkins and countersigned by Dr Mercer as Chief Executive Officer designate.[1]

1.029 In August 1997 the Board approved capital investment in IT systems hardware and "Project Iris" (see paragraph 1.088) got under way the following month. Complementary applications to those making up the SMS system (such as ORSOS Theatre Management system and *Peoplesoft* Materials Management and Accounts Payable systems, where there was not a suitable SMS module available) were established as separate projects. Dr Mercer was sponsor of all the projects and also chaired the Project Control Group that had been set up to oversee their implementation (see paragraph 1.085).

1.030 The Patient Registration and Accounting modules were implemented during April and May 1998, replacing the former Admission, Discharge and Transfer systems for all except Mental Health patients. CCH has also set up a central registration process to handle referrals from General Practitioners using the new system.

1.031 The Hospital-Wide Scheduling module was implemented in May 1998 for all outpatient clinics that were previously scheduled using the old system. Other clinics have since been added. This is a multi-resource scheduling system that can be used to tailor appointments according to patient needs and ensure that all clinicians and equipment resources are available for an appointment.

1.032 The Electronic Medical Record module was implemented in September 1998 and, by the end of the year, seven years of historical laboratory and radiology results were added. This module of the SMS system holds the history of medical treatment for every patient and is also linked to the National Health Information System, maintained by the Ministry of Health. Patients are indexed using their National Health Index number.[2]

1 Dr Mercer was issued with a New Zealand work permit on 8 April 1997, and his employment contract was signed on 10 June 1997.

2 The index number is a unique identifier for every user of health care services.

1.033 The Radiology Management module was also implemented in September 1998. This module allows clinicians to order radiology services (such as x-rays) electronically and have the results transmitted back to them electronically. It also covers all other aspects of the radiology business, such as patient and film tracking and results reporting.

1.034 Again in September 1998, the Electronic Orders module was piloted in an inpatient ward and has been implemented elsewhere progressively since then. This module allows clinicians to order electronically a patient-related test, procedure, or therapy.

1.035 In February 1999 an attempt to implement the Laboratory module was unsuccessful due to software problems and process issues. Implementation is currently being re-evaluated. This module manages sample collection and results processing, and includes patient and specimen tracking using bar coding. The delay has meant that, as a contingency measure, the existing system has had to be upgraded to a Year 2000 compliant version.

1.036 The ORSOS Theatre Management system (which is not part of the SMS system) was implemented in December 1998. This system covers the scheduling of operations, equipment and surgical instrument tracking, inventory management, clinical documentation, and the management of surgical procedures in operating theatres.

1.037 The *Peoplesoft* Materials Management and Accounts Payable systems (also not part of the SMS system) were implemented in February 1999. These systems replace the Meditech Supply system and were required for Year 2000 compliance.

Managing the Purchase

What We Looked At

1.038 Guidance as to good practice for identifying, evaluating, and selecting IT systems is available from a number of sources. The Information Technology Association of New Zealand (ITANZ) and the State Services Commission have published guidelines specific to the selection, procurement and management of IT projects. The 1995 Audit Office guide *Good Practice for Purchasing by Government Departments*[3] and the 1994 Ministry of Commerce guide *Government Purchasing in New Zealand: Policy Guide for Purchasers* provide benchmarks to measure purchasing practices against.

1.039 Our review of how CCH went about selecting and purchasing a new IT system to meet its needs consisted of:

- assessing the adequacy of CCH's policies and procedures for purchasing major capital items, including IT systems;
- testing compliance with those policies and procedures; and
- testing whether the procedures followed met accepted good practice guidelines.

Policies for Major Purchases

1.040 CCH had adequate policies and procedures for the purchase of major capital items. They addressed the development, review and approval of business cases and the procedures to be followed in obtaining capital expenditure approval. The policies and procedures were complied with.

1.041 The steps that CCH followed in the selection of the ANSO system (see paragraph 1.013) represented good practice in purchasing a major IT system. However, the steps did not reflect formally documented policies and procedures. The

3 September 1995, ISBN 0 477 02848 9.

same steps were followed in evaluating and selecting the SMS system – in that each step was completed – but not in the expected sequence (see paragraph 1.048).

Conclusion

1.042 Our conclusion is that CCH complied with its policies and procedures for the purchase of a major IT system that were in force at the time of selecting and purchasing the SMS system. While those policies and procedures were adequate they have since been reviewed and updated, resulting in:

- the addition of policies and procedures for comparing and analysing options to support prioritisation in the Business Plan;
- a new policy on "Project Justification – Business Case Preparation"; and
- establishment of a Project Support Unit – to ensure that business cases, project plans, communication strategies, and accountabilities meet minimum set standards.

1.043 Procedures for major IT system purchases have been reviewed and are now formally documented.

Needs Analysis and Business Case

1.044 CCH's "vision" of what it wanted its IT systems to deliver (see paragraph 1.004) drove the development of both the ISSP and the Business Plan. There was a clear understanding that – as existing business processes, procedures and information systems needed major redesign to achieve the vision – there was little point in spending valuable time and resources documenting existing systems for specification purposes.

1.045 Development of the ISSP was based on analysis of CCH's needs from clinical, business, and technical perspectives. The ISSP:

- assessed the capability of existing systems to deliver the "vision";

- detailed the deficiencies in existing systems, which were described as lacking interfaces to other systems and suffering from poor supplier support; and
- adequately defined the high-level specifications for a new integrated IT system, which were used in the evaluation of potential solutions.

1.046 The existing systems were primarily administrative rather than clinical, in that few maintained clinical data that directly helped with providing care to the patient. There was also little feed-back on actual resources used for treatment – which meant that it was difficult to link activities to costs, analyse budget variances, or develop realistic budgets.

1.047 Application of the ISSP during 1995 focused on improving the support provided by existing systems, maintaining a balance between meeting the immediate demands of the business and achieving longer-term goals from implementing new systems. Work began on developing high-level and detailed business cases to support the investment required in new IT systems. By December 1995, 45 information system projects were in progress and a further 41 were waiting funding and approval.

1.048 A good quality business case was prepared for the IT system for which the Community and Support Services department issued a request for proposals (see paragraph 1.013). However, during 1996 CCH incurred significant costs ($2.6 million) on developing detailed business cases for the systems that were to comprise the IHIN (see paragraph 1.017), which were not completed until after the SMS and Cerner systems had been demonstrated and the request for proposals issued to identify a preferred supplier. In addition, no detailed system specifications were prepared – reliance was placed on the high-level specifications in the ISSP.

1.049 Considerable effort and resources were also spent on "Project Quantum" during 1996.

1.050 By selecting an "off-the-shelf" packaged solution as the core of its integrated IT system CCH minimised the potential risks to the organisation.

Conclusions

1.051 In our view, the ISSP represented an adequate needs analysis for the new IT system that CCH wanted. Nevertheless, it was not good purchasing practice to select the successful supplier and system before completing proper business cases and detailed system specifications – which should have been used in evaluating the proposals.

1.052 We are also of the view that CCH, having selected the lower-risk option of an "off-the-shelf" solution in the form of the SMS system, need not have completed the detailed business cases to support the purchase of the SMS system after it and the Cerner system had been demonstrated and the request for proposals issued to identify a preferred supplier.

Conducting the Tender

1.053 The EDS Health Industry Executive had translated CCH's broad requirements for a clinical services system into the IHIN. In accordance with CCH's requirement that an "off-the-shelf" packaged solution was preferable to developing a system from scratch, EDS approached a number of health information system providers in the USA to identify any that would be interested in providing systems solutions in the New Zealand market. There may have been some advantage to CCH if, considering EDS's global health industry associations, EDS had cast the net more widely to identify potential solutions.

1.054 Given the time already spent on developing business cases and the known results of the SMS and Cerner evaluations, the ISSC recommended to the Board, and the Board agreed, that a fast-track process for evaluating any tender proposals be adopted. The aim was earlier implementation and achievement of benefits by:

- limiting the choice of suppliers and systems; and
- performing less detailed evaluations of systems.

1.055 In July 1996, CCH issued a request for proposals to SMS and Cerner for the supply of the modules to make up the

IHIN, concentrating on pricing and support issues. Two other organisations – MDIS and Trak Systems Pty Ltd – also asked for, and were given, the opportunity to submit a proposal.

1.056 Proposals were received from all four of those suppliers except that SMS submitted its proposal jointly with EDS. Because EDS had assisted CCH to find potential suppliers, EDS would have had a clear conflict of interest in also assisting CCH to evaluate the proposals. CCH therefore engaged other consultants to assist it in that task (see paragraph 1.023).

1.057 SMS then indicated that it wished to submit a bid on its own. CCH took appropriate legal advice and, consistent with accepted good practice, reissued the request for proposals in September 1996. The request was not reissued to MDIS because it had said it would not bid a second time.

1.058 Because of EDS's withdrawal from the joint proposal with SMS and the need for the successful supplier to work with EDS as IT systems manager, CCH engaged EDS to provide limited assistance in the evaluation process for proposals received from the second request. EDS collected the evaluation results, which were then collated by CCH staff. The evaluation results were confirmed with users.

Conclusions

1.059 In our view, CCH conducted the tender in accordance with proper procedure.

1.060 However, we are also of the view that CCH – having already employed EDS as its IT ***systems manager*** (with the consequent reduction in in-house expertise) – by also engaging EDS as its IT ***adviser*** put itself in the position of being overly dependent on EDS.

1.061 That dependency created the risks that CCH might not receive from EDS the impartial advice it had a right to expect, and could be perceived to be open to influence from EDS in reaching its decisions on IT systems. Nevertheless, we have seen no evidence to suggest that either of those risks was realised. Furthermore, the contract between CCH and EDS contained conditions designed to protect CCH from conflict of interest on the part of EDS.

Selecting the Preferred Supplier

1.062 Given CCH's "vision" for a new IT system and its preference for a low-risk solution, the decision to evaluate potential solutions based on demonstrations and workshops of a tried and true system was reasonable. However, the choice of supplier and system was made from the limited selection of two interested potential suppliers out of the nine that EDS said it had approached.

1.063 Of the nine organisations that EDS told CCH it had approached, only two – SMS and Cerner – expressed interest. Both were asked to demonstrate their systems and conduct workshops for clinical staff, which they did before CCH issued the request for proposals. MDIS and Trak Systems demonstrated their systems after putting in proposals in response to the request.

1.064 Based on the demonstrations and workshops, clinical and information systems staff (in conjunction with EDS) evaluated the functions that each available module would deliver. Detailed criteria against which the functions could be evaluated were not available (because of the decision to not document existing processes), but the evaluation process was thorough in establishing whether the functions provided would satisfy requirements for a clinically based information system.

1.065 A significant factor in the users' assessment was that SMS was able to demonstrate established modules, whereas some of the Cerner modules had yet to be developed. As neither supplier had an adequate theatre management module, the ORSOS system – recommended by SMS as a suitable solution that could be integrated with its system – was selected.

1.066 Evaluation of the systems demonstrated by SMS and Cerner, and evaluation of the proposals received from the second request, resulted in the ISSC submitting a paper to the Board stating that SMS should be the preferred supplier and proposing further negotiations with the company.

Conclusions

1.067 CCH chose its preferred supplier from the limited range of two suppliers found by EDS – CCH having discounted two other potential suppliers that responded to the first request for proposals, only one of which responded to the second request and was not considered suitable. In effect, CCH chose the selective tender method of establishing potential suppliers.

1.068 Subject to that choice, in our view CCH followed accepted good practice in selecting SMS as its preferred supplier.

Letting the Contract

1.069 On 21 November 1996 (three days after his appointment as Acting Executive Chairman) Mr Jenkins wrote to Deborah Dickson-Freund of SMS. He undertook *to initiate formal discussions to further define the business arrangements, and negotiate in good faith toward an agreement where the envisioned Integrated Health Information Network can be implemented.*

1.070 From that time on Mr Jenkins continued to take sole responsibility for negotiating the contract with SMS – although he was assisted later by Dr Mercer in securing terms and conditions that achieved a better sharing of risks between CCH and SMS.

1.071 The Deputy Chairman – Dr Richard Bush – told us that the Board was kept informed of progress in the contract negotiations, but it was not party to the details of the contract.

1.072 The contract was finalised and on 13 March 1997 signed on behalf of CCH by Mr Jenkins and Dr Mercer as Chief Executive Officer designate.

Reporting to the Board

1.073 Shortly after his appointment in November 1996, Mr Jenkins suggested that the Board (which normally met monthly) should meet weekly. His intention was to keep the Board informed of the work of the change team that he headed (see paragraph 1.127). However, weekly meetings did not occur because members came from diverse locations.

1.074 There is a lack of documentation on what information was being provided to the Board at this time. We have been told that there were "in camera" information sessions before Board meetings without company members or members of the change team present, but no record was made of these sessions. Members of the change team also reported to the Board at its meetings.

Managing the Project

Administration of Information Systems

1.075 The Board established an Information Systems Steering Committee (ISSC) in July 1995 to provide high-level oversight and keep the Board informed of information system issues (see paragraph 1.003).

1.076 The remit of the ISSC was to oversee development of the ISSP and any projects that followed. The ISSC had terms of reference, met monthly, and a formal record was kept of its meetings.

1.077 The ISSC reported to the Board on issues that required its attention and submitted proposals to the Board for approval. Key issues and proposals submitted during the acquisition process included:

- tendering for IT systems advice and facilities management services;
- evaluation of the SMS and Cerner systems;
- tendering for implementation of the IHIN;
- fast-track evaluation of proposals from the second request; and
- recommendation of SMS as the preferred supplier.

1.078 In January 1996 CCH employed a Chief Information Officer. Until this time IT system services had been delivered and supported by an in-house Information Services team, which was overseen by an Information Services Manager (who reported to the General Manager Finance and Information Services).

1.079 The contract with EDS to provide facilities management for CCH's IT systems was signed in April 1996.

1.080 The Information Services team (the team) has undergone significant change during the course of implementing the IHIN. The facilities management contract with EDS began to be phased out from February 1999, with final withdrawal of services in June 1999. The services have been brought back in-house. It has taken time to put appropriate staffing structures in place, employ resources with the required skills, and build up expertise in the systems being supported.

1.081 The team has been successful in greatly improving the reliability and availability of CCH's information systems. For example, the old patient information systems were unavailable for 4 hours a night; the new SMS system modules have one scheduled close-down for maintenance and "housekeeping" of 3 to 4 hours a month. The team provides a 24-hour/7 days a week helpdesk service and supports 1,600 personal computers (compared to 400 in 1994).

1.082 The team is now confident that it is in a position to develop and implement the changes required to address user-identified problems. Many of those problems relate to getting information out of the system (reports and customised screens of data) and using that information to improve organisational management and service to patients. Users expressed to us their satisfaction with the service they now receive from the helpdesk staff.

Implementation

1.083 We interviewed a total of 26 CCH staff – 11 of whom were clinicians (including the Chief Executive Officer) and three were nurses. Other staff in the 26 were the Chief Information Officer, information systems staff, and clerical staff. We sought to establish their views on:

- how the implementation was being managed – concentrating on whether processes and procedures for the effective management of change were in place;
- what problems they had identified with the new IT systems; and
- whether the new IT systems are of benefit to them in their jobs and to CCH in the management of its business.

1.084 CCH faced some significant challenges in implementing its "vision". The systems being implemented were not just automating the existing manual processes or replacing existing IT systems. An integrated system based on electronic medical records, documented care plans, electronic orders, and hospital-wide scheduling would significantly change the way staff did their jobs and CCH managed its business. In particular, the use of technology would become an integral part of the way staff did their work, often in areas where computers had not been used before. This change involved not only the implementation of a new IT system (which is significant in itself) but also the process and culture changes necessary for CCH to achieve its "vision".

1.085 A Projects Control Group (PCG) was set up in July 1997 to provide immediate oversight of the six projects required for implementing the SMS system modules. The PCG:

- functioned as a steering committee;
- was chaired by Dr Mercer as Chief Executive Officer, who was sponsor of the projects; and
- met fortnightly during the initial stages.

1.086 It was believed that Dr Mercer's substantial experience as a clinician and of IT systems would be of significant benefit during implementation of the SMS system. This was one of the reasons contributing to his appointment as Chief Executive Officer. Dr Mercer was a driving force behind the project and since his departure in June 1999 no replacement as clinical sponsor has been appointed. Some senior clinicians told us that they feel the overall success of the implementation is now suffering from the lack of a suitably enthusiastic and committed sponsor.

1.087 The PCG now meets monthly. Membership of the group includes the Chief Information Officer, the Chief Operations Officer, the Chief Nursing Executive, three clinical staff representatives, and a representative of SMS. (EDS was also represented while it was engaged to provide IT systems management.)

1.088 "Project Iris" was begun in September 1997 as an umbrella for the projects to implement the six modules comprising the SMS system:

- Electronic Orders;
- Clinical Repository (electronic medical records);
- Patient Registration;
- Patient Accounting;
- Radiology; and
- Scheduling.

1.089 Separate projects were begun in 1998 for implementing the ORSOS Theatre Management system and the *Peoplesoft* Materials Management and Accounts Payable systems.

1.090 Each project was set up with a Project Manager and appropriate representation from the areas of the business that would be affected. These representatives included:

- user liaison (a representative from the appropriate hospital department);
- an application analyst (for in-house business expertise); and
- an SMS consultant.

1.091 The level of planning for each project was adequate, including sufficient detail of the tasks necessary and the resources required to perform those tasks. A budget and milestones were set for each project and progress measured and reported against both.

1.092 A strong feature of all projects to implement the SMS modules was the effort and resources put into training and user support during the initial stages of implementation. Users were given the opportunity to attend a number of available training sessions and fit their attendance into their work schedules. This approach was designed to ensure that as many users as possible could attend. User training and support during implementation was rated highly by many of those we interviewed.

1.093 Implementation consists of three stages – implement, optimise, and redesign. The PCG made a conscious decision to

implement systems as soon as possible, rather than allow time for each system to settle down before implementing the next module. While this approach is understandable considering the integrated nature of the system being implemented, it has adversely affected the ability of information systems staff to address issues and problems to users' satisfaction.

1.094 The PCG set up a Project Issues Resolution Committee (PIRC), which meets regularly and prioritises the action to be taken to address issues and problems. Two representatives from each clinical/operational area make up the PIRC. While it functions well as a forum for users to report problems and issues, the skilled resources to address them are in short supply.

Conclusion and Recommendations

1.095 The PCG and PIRC need to take stock of where they are with the implementation of core systems and establish a planned approach to improving clinical ownership.

1.096 We recommend that the approach include the following:

- ***Creating an Issues Register***, which should identify those problems that require the most urgent attention. The Issues Register should be used for the ongoing identification and tracking of issues and problems through to resolution. The prioritisation of issues should be determined and agreed in consultation with users on the PIRC. Significant gains in user acceptance and satisfaction with the systems could be achieved by developing the reports for Emergency and Outpatient departments that would improve the systems' usefulness in day-to-day management.

- ***Identifying and assigning resources to developing and implementing Healthcare Guidelines*** (the "Clinical Pathways" observed in the Sioux Falls Hospital in 1994). Communications and consultation, particularly with clinicians, are critical elements in achieving the benefits from implementing Healthcare Guidelines. The SMS system provides the infrastructure and systems that facilitate the concept, which has the potential to deliver significant efficiency gains.

1.097 In a draft of this report we included a recommendation that CCH pursue its intention to appoint a Theatre Manager and make full use of the ORSOS system – which has the potential to achieve significant efficiencies and cost savings in the use of expensive resources. Considerable work is still to be done to convince senior clinicians (surgeons and theatre support staff) of the benefits, and to ensure their buy-in to a system that does not directly help them do their jobs of performing surgery. We are pleased to record that a Theatre Manager was appointed in July 1999.

1.098 We also recommend that a suitably qualified and committed project sponsor to replace Dr Mercer be identified and appointed.

Meeting Objectives and Specifications

1.099 Our observations are that the PCG and PIRC have been active in ensuring that major problems that occurred immediately post-implementation have been quickly addressed – however, they have not put adequate procedures in place to track all issues through to resolution. The project teams have documented records of problems, what needs to be done, and the progress to achieve resolution (liaison with SMS, internal support resource) but this information is not readily available to the user(s) who identified an issue.

1.100 An external consultant performed an independent quality assurance review of "Project Iris" in November 1997. While the consultant was reasonably confident that phase one implementations (as scoped) would be delivered on time, the consultant also expressed concern about the lack of planning and management covering the whole scope of "Project Iris". Subsequently, phase one implementations were delivered on time.

1.101 The consultant's major concern was that there had been no planning for the system optimisation and process redesign stages that are expected to deliver the monetary savings from "Project Iris".

1.102 Implementation of the SMS modules has introduced new computerised processes and procedures. Staff have been trained to use the modules, but little work has been done to

determine how work processes and procedures can be redesigned to maximise the benefits from the investment in IT systems. The SMS contract provides for 12 person-months of resource for this optimisation and process redesign work. Some of that work has started and skills are being developed in-house to do more.

1.103 The most significant redesign effort to date has been in the implementation of Centralised Registration. Previously, to register a patient for treatment the General Practitioner wrote to the department that would treat them. Letters sometimes went missing and Practitioners had some difficulty obtaining information about their patients.

1.104 Now, all registration letters are sent to a central point where trained staff enter the relevant information and check patient details against the Patient Registration system and the National Health Index.[4] This process is more efficient and has improved the quality of information in the system – benefiting both clinicians and management.

1.105 Matching the SMS Pharmacy module to user requirements was expected to be difficult and that proved to be the case. CCH has chosen not to implement this module due to the differences in procedures between New Zealand and USA hospital pharmacies. SMS has agreed a credit of costs for that module to be applied to an alternative solution.

1.106 Implementation of the Laboratory module – expected to be relatively straightforward – has also proven more difficult, partly due to software problems (see paragraph 1.035). While evaluation results show a high level of user satisfaction, implementation problems have also been caused by the differences between the way the system works and the business processes. Implementation of this module is currently being re-evaluated. (It was originally scheduled for November 1998, was rescheduled for September 1999, is now rescheduled for 2000, and has cost more than $600,000 to date.)

1.107 Because of the delay, the existing Laboratory system has had to be upgraded to a year 2000 compliant version as a contingency measure. We understand that Laboratory staff may choose to retain the existing system.

4 The National Health Index is maintained by the Ministry of Health and consists of a unique identifier for every user of health care services.

1.108 The failure to successfully implement the Laboratory module indicates shortcomings in the evaluation of its ability to meet users' needs. However, the evaluation results clearly indicate not only a preference for the SMS module but also enthusiasm for its ability to meet users' needs. The difficulties with implementation suggest that Laboratory processes and procedures should have been more thoroughly documented and used as a basis for the evaluation criteria.

1.109 Our interviews with users brought mixed responses. The Chief Executive Officer considered that he and senior managers now had good information available to manage the hospital's resources and assist them in securing appropriate funding. Clerical staff and business managers are also positive about the new technology and the improvements to the quality of management information in the system.

1.110 Departments that use the system a lot, such as Central Registration, have gained greater familiarity with the system and confidence in using it and rate it highly. The electronic medical record is generally considered an excellent concept and those who are making good use of it are very positive about the benefits of having historical patient information and test results readily available. As one senior clinician put it – the challenge is getting clinical buy-in and commitment and getting good information into the record.

1.111 Some users are still relying on paper records, with the result that the electronic record is not always up to date. Clinical staff in departments such as the Fracture Clinic, Outpatients, and Emergency are frustrated by the detailed data entry requirements for registration and generating electronic orders, but they acknowledge the positive aspects of improved management information.

1.112 Common complaints included:

- identified problems not being fixed in a timely manner;
- information not being presented on computer screens in a user-friendly format;
- some processes being unnecessarily complex;

- frustration with having to log in to modules separately, indicating that the system is not as "integrated" as claimed; and
- customised reports not being developed yet.

1.113 The specific problems identified to us during the review have been discussed with the project team.

1.114 A number of staff told us that the version of the system that is being implemented is not the same as that demonstrated by SMS. During its negotiations with SMS, CCH's objective was to purchase a "tried and true" version of the SMS system rather than a newer version that had not been fully implemented in another hospital. In addition, CCH chose not to use a "Windows" type of access software for all workstations, and a clinical application that was demonstrated was not part of the SMS system.

Conclusions

1.115 We consider that there have been significant achievements in delivery against the objectives established in 1994. The ISSP identified four major needs to be met by the implementation of a selected system. Figure 1.1 on pages 38-39 provides a summary of the extent to which we consider that the implementation of the SMS system has met, or has the potential to meet, those needs.

1.116 Implementation of the SMS, ORSOS and *Peoplesoft* systems has been reasonably successful. The systems have been delivered within budget and with only relatively minor slippage against timelines. Training and support provided as part of the implementation was good and refresher training is ongoing.

1.117 CCH now needs to consolidate its position by addressing the problems and issues identified by users. More importantly, resources need to be allocated to the redesign of processes and procedures to gain the maximum benefit from the investment in technology.

Figure 1.1
Comparing the SMS System with CCH's Needs

1. Collecting and providing data at the point of care and only collecting data once	Patient Registration ensures that data is collected (once) for all patients [a significant improvement]. Scheduling, Radiology Management and Electronic Orders ensure that relevant data is collected once, is readily available to clinicians and risks of loss of data are minimised. The implementation of Care Plans (Healthcare Guidelines) will be a significant step towards meeting this need in full. The system has the capacity to provide this facility, but the resources required to develop and agree the guidelines are the current limitation.
2. Lifetime history of care	The Patient Registration system (with 7 years of historical laboratory and radiology data added) and links to the National Health Index provide clinicians with up to date patient information from "one system".
3. Information Analysis – management information	Scheduling, Radiology Management and Electronic Orders provide business managers with complete information on the services being provided by CCH. Patient Accounting ensures that costs are accurately recorded for all cases. The information now being collected by CCH systems has the potential for clinical staff to analyse the effectiveness of treatment, patterns of services and demand for services. Although the ORSOS system is not part of SMS, it has the potential to provide Theatre Managers with good management information and does provide them with the tools to effectively manage theatre resources.

4. Corporate Infrastructure	A critical success factor for the strategy was clinical ownership and involvement. Clinical staff have been involved in all aspects of the project, from the development of the ISSP, through to the evaluation, selection and implementation of systems solutions. Clinical ownership, buy-in and commitment, in their fullest sense, have not been achieved. The system has introduced a level of management control and accountability that was not in place with previous systems. It is fair to say that the primary purpose of some modules is to collect management information as opposed to providing direct assistance to the user in the performance of their job. The system does have the potential and we believe that, as problems are fixed and systems specific to the delivery of health care (such as Care Plans) are introduced, clinical ownership should improve.

Monitoring Progress

1.118 The projected costs of implementing the IHIN were established at $25.79 million. In addition to the actual cost of the SMS software ($5.1 million), the projected costs comprised all key components including:

- the costs of other third party software;
- hardware and network components;
- capitalisation of salaries;
- capitalisation of interest costs for working capital;
- contract staff; and
- implementation costs.

1.119 Progress against that budget has been measured throughout the project. As at 30 June 1999, CCH had incurred costs of $17.6 million and this is within the budget to date. CCH expects to complete the implementation of the SMS system (which does not include the ORSOS or *Peoplesoft* systems) within the projected costs.

1.120 The ongoing costs (estimated to be $2.78 million a year) – including SMS licensing and support agreements, in-house support services and equipment leasing – are incorporated in operational budgets.

1.121 There has been some slippage in meeting the implementation programme deadlines set in July 1997. This has meant that existing systems have had to continue to operate. Patient Registration went live on time but the other core modules (Radiology, Orders and Clinical Record) were delivered between one and three months later than scheduled. Costs are currently within budget and we do not consider the slippage to be a major issue for a project of this size and scope.

Post-implementation Review

1.122 To date CCH has carried out only limited formal post-implementation reviews. Resources have been focused on implementation and support issues. We consider reasonable CCH's assertion that an effective post-implementation review of such an integrated system is not possible until all modules are live and any necessary process changes made.

1.123 The one area where process redesign has been completed (Centralised Registration) has been reviewed, with positive results. A post-implementation review of the Radiology Management system was also conducted in February 1999. In general terms, results were positive. However, the inability of the system to produce adequate statistical reports, and continued failure of the auto-fax facility to send results to General Practitioners, had been issues for some time and were beginning to cause a negative impression of the system. The auto-fax facility is still outstanding.

1.124 The Radiology system has also recently been affected by a problem of compatibility of field sizes in two interfacing systems. This resulted in the system being out of action for three days until an interim solution was put in place. A permanent solution is currently under discussion with SMS.

Other Management Considerations

Conflict of Interest

1.125 Mr Jack Jenkins met Dr Leo Mercer in August 1996 while on a Health Waikato Limited delegation to the USA to investigate health information systems. At that time Mr Jenkins was not associated with CCH.

1.126 The Ministers of Health and Finance appointed Mr Jenkins Acting Executive Chairman of CCH on 18 November 1996. The previous Chairman, Mr Rob Thompson, resigned from the position on the same date. (However, Mr Jenkins did not receive a formal letter of appointment from the two Ministers until four weeks later.)

1.127 The then Chief Executive of the Crown Company Monitoring Advisory Unit (CCMAU), Mr Andrew Weeks, asked Mr Jenkins to work on site for three to five days each week. Mr Weeks also assisted Mr Jenkins to bring together a change team of four – two consultants then working for CCMAU and two other consultants – which set about managing the affairs of CCH following a financial crisis. Their initial task was to understand and control costs, and then to restructure the organisation with a model of clinical leadership. Issues which were immediately addressed were those of contracting with the (then) Regional Health Authority, capital works, and advancing the IT systems proposal.

1.128 A member of the change team told us that the situation was analogous to a receivership, with the financial crisis meaning that the Ministers and CCMAU had sought to take urgent action to stem the escalating losses. Mr Weeks was frequently consulted about actions taken at this time.

1.129 The resignation of Mr Harrison as Chief Executive Officer of CCH required the change team to seek a new chief executive. It became apparent to the change team that it would be most useful to have a chief executive with skills in the health information technology area.

1.130 The first approach to Dr Mercer about the possibility of applying for the chief executive position came from Ms Dickson-Freund of SMS late in November 1996. It is not clear how or by whom Ms Dickson-Freund was prompted to make this approach.

1.131 However, Dr Mercer agreed to Ms Dickson-Freund sending his curriculum vitae to CCH, which she did on 25 November 1996. (Dr Mercer had previously visited New Zealand in May 1996 as mentioned in paragraph 1.015.)

1.132 In December 1996 Mr Doug Martin (a member of the change team), at Mr Jenkins' suggestion, visited Dr Mercer in the USA and discussed the chief executive position with him. At this point Dr Mercer reported that he recognised potential for a conflict of interest, and determined to undertake no additional consultancy work for SMS. He carried out his last consultancy in late-December 1996/early-January 1997.

1.133 At the end of January 1997 Mr Jenkins asked Dr Mercer to advise CCH on the SMS contract from the USA. As a result, Dr Mercer provided CCH with technical advice on the feasibility of the contract as currently specified, and on how to get SMS to share more risk in the terms and conditions. Dr Mercer and Mr Jenkins both say that this achieved benefits for CCH in the contract negotiations.

1.134 The vacancy for Chief Executive Officer was advertised on 10 January 1997. Dr Mercer visited New Zealand, was interviewed by a number of Board members (including Mr Jenkins and Dr Bush, the Deputy Chairman), and agreed to accept the position in the week commencing 5 February 1997.

1.135 A contract of employment was negotiated. It recognised the potential for a conflict of interest by setting out the circumstances in which Dr Mercer could undertake consultancy work in New Zealand. The contract:

- permitted him to continue his consultancy work in the USA – which was to enable him to continue some work already in progress at Thomason Hospital; but
- provided that any consultancy work in New Zealand was to be done only with the agreement of CCH, which was to receive all payment for that work.

1.136 Dr Mercer's remuneration from CCH consisted of two components – the amount relating to his duties as Chief Executive Officer and a fixed sum for consultancy work in New Zealand. The latter component had the effect of removing the potential for Dr Mercer to increase his income by carrying out consultancy work in New Zealand.

1.137 Dr Mercer was not involved in CCH's evaluation and selection of the SMS system. The ISSC had made its recommendation to the Board regarding SMS, SMS had been advised that it was the preferred bidder, and negotiations were proceeding with SMS, before Dr Mercer agreed to his curriculum vitae being forwarded to CCH. His only involvement with the purchase of the SMS system was in assisting Mr Jenkins to negotiate the contract to ensure that the conditions obtained were advantageous to CCH.

Conclusion

1.138 People not aware of all the facts as we have described them may have formed the perception that there was a conflict of interest. However, nothing has come to our attention to lead us to the view that any conflict of interest in fact existed – in the case of either Mr Jenkins or Dr Mercer – in selecting and contracting with SMS as the preferred supplier of CCH's new IT system.

Acting Within Delegated Authority

1.139 Mr Jenkins personally took charge of the negotiations with SMS from the time he wrote to SMS on 21 November 1996 (see paragraph 1.069). His position as Acting Executive Chairman can be presumed to import sufficient authority for him to do so since it did not entail any final expenditure commitment on the part of CCH.

1.140 In a report dated 6 March 1997 Mr Jenkins informed the Ministers of Finance and Health, CCMAU, and the Treasury of his intention to enter into an agreement with SMS.

1.141 Mr Jenkins (together with Dr Mercer as Chief Executive Officer designate) signed the finalised contract on 13 March 1997. The Deputy Chairman, Dr Bush, told us that the Board knew the contract was to be signed and had no concern about Mr Jenkins' authority to do so. Nevertheless, there is no record that Mr Jenkins (whether alone or in company with one or more others) had express authority from the Board – by way of a formal delegation – to sign the contract with SMS.

1.142 The circumstances of Mr Jenkins' appointment and the nature of the task he was appointed to carry out were a matter of common understanding. It seems clear that the circumstances were abnormal and that Mr Jenkins was expected to "get on with the job in hand". Nonetheless, we observe that his letter of appointment from the shareholding Ministers included the plain statement that *Primary accountability remains to shareholding Ministers* ***through the board of Directors*** [our emphasis added].

1.143 The Board finally approved capital investment in IT systems (including SMS) in August 1997 – five months after the contract with SMS was signed.

Conclusion

1.144 We think that a purchase involving such a major amount of capital expenditure should have had the express and unequivocal approval of the Board.

Contents

Summary

The Health Funding Authority (HFA) contracts for the provision of a specialist sexual health service in the Wellington region. For many years Capital Coast Health Limited (CCH) had provided the service, but CCH decided that it no longer wished to do so.

As a result of receiving CCH's notice of intention to cease providing the service, the Wellington office of the HFA (HFA Wellington) took steps to find a replacement provider. The provider it chose was Wellington Independent Practice Association (WIPA).

We received a complaint in April 1999 from the Hon Annette King MP about the manner in which the contract with WIPA had been let, and we decided to investigate what had taken place.

In summary, our conclusions are that:

- HFA Wellington did not consult with interested parties before determining the specification for the service that it included in the request for proposals. We believe it should have consulted. The request for proposals by which potential providers were invited to submit bids for the service reflected the service then being provided by CCH.
- HFA Wellington applied a proper method of evaluation to the proposals received. However, it did not determine the actual criteria used until after the request for proposals had been issued. Consequently, potential providers did not know the precise criteria against which their bids would be evaluated.
- HFA Wellington had a rationale that tended to dictate the kind of service it wanted to purchase – which differed from the service that CCH had been providing. The documentation given to potential providers did not clearly reflect this rationale.

- HFA Wellington did not document its reasons for selecting WIPA as the preferred provider – other than that WIPA was the top-scoring provider at the short-listing stage of the evaluation and had the most cost-effective proposal.
- After selecting WIPA as the preferred provider, HFA Wellington negotiated with WIPA to provide a service that fitted its rationale. The outcome of the negotiations (and the resulting contract) is that the new sexual health service being provided in the Wellington region is significantly different from the service for which HFA Wellington issued the request for proposals.
- Because HFA Wellington came to the view that it wanted a different service from that described in the request for proposals, an equal opportunity should have been afforded to all potential providers to bid for the revised service. At the least, the four short-listed providers should have had that opportunity.

Introduction

The Reason for this Report

2.001 This report is the result of an investigation we carried out following a complaint in April 1999 from the Hon Annette King MP about the manner in which the Wellington Office of the Health Funding Authority (HFA Wellington) had let a contract for the provision of a specialist[1] sexual health service.

2.002 The Audit Office has a particular interest in purchasing systems. If the processes by which purchases are made are seen as unfair, and if potential suppliers consequently do not have confidence in the tendering systems of public bodies, the result may be less interest in responding to future invitations to tender. As we observe in our guide *Good Practice for Purchasing by Government Departments*, the taxpayer is not well served by poor responses to tenders issued by public bodies.

The Criteria for Our Investigation

2.003 The main source of the criteria for our investigation was the *Contracts and Purchasing Handbook* (the *Purchasing Handbook*) compiled and used by the former Central Regional Health Authority. HFA Wellington was using the *Purchasing Handbook* in the absence of a formal Health Funding Authority replacement. (The HFA now has its own purchasing manual.)

2.004 We accept that the contents of the *Purchasing Handbook* represent sound purchasing practice.

2.005 We also had regard for the guidelines in our *Good Practice for Purchasing by Government Departments*.

1 "Specialist" connotes a health service that is overseen by someone medically qualified in the diagnosis and treatment of sexual diseases.

2.006 Media comment on WIPA being the successful bidder to provide the service was open to the implication that conflict of interest could have been a factor in the decision to select WIPA. We looked particularly for any evidence of a conflict.

Background

2.007 A specialist sexual health service had been provided for a number of years by Capital Coast Health Limited (CCH), based at Wellington Hospital. CCH provided the service under contract to HFA Wellington at a cost of $800,000 a year, including the cost of laboratory tests.

2.008 In accordance with the contract, on 30 November 1998 CCH gave six months notice to HFA Wellington that it intended to cease providing the service.

2.009 As a result, on 12 December 1998 HFA Wellington initiated the purchase of a replacement service by advertising a *Request for Proposals* (RFP) from prospective providers. Prospective providers were invited to obtain the relevant RFP documentation as the basis for their proposal.

2.010 HFA Wellington received seven proposals. Its evaluation of the proposals resulted in the proposals of four prospective providers being short-listed for further examination. In descending order of evaluation scores they were:

Wellington Independent Practice Association (WIPA)

Family Planning Association

Healthcare Aotearoa

Hutt Valley Health Limited.

2.011 Each of the short-listed providers was interviewed, and WIPA was identified as the preferred provider. Discussions were then held with WIPA, and the particulars of the service that HFA Wellington wished to purchase and WIPA to provide were determined.

2.012 On 31 March 1999, the Purchase Board (see paragraph 2.066) approved WIPA as the new provider of the service. On 13 April 1999, HFA Wellington wrote to WIPA to document the agreement for purchasing the service.

The Request for Proposals

Prior Consultation

2.013 The *Purchasing Handbook* states that the HFA has a duty to consult on the purchase of health and disability services. The *Purchasing Handbook* goes on to state that the duty to consult arises out of the obligation to act fairly.[2]

2.014 However, HFA Wellington carried out no consultation before issuing the RFP. The RFP documentation was based on a description of the existing service provided by CCH.

2.015 HFA Wellington told us that, because the RFP essentially described the existing service, there seemed no need to consult. There was also time pressure, in that it was vital for the RFP to be released before Christmas 1998. This timing was necessary in order to allow proposals to be submitted and assessed after Christmas, and to allow the new provider sufficient time to make necessary arrangements before taking up the contract at the end of June 1999.

2.016 While timing is always an issue, extensions can be negotiated. The *Purchasing Handbook* required that when (as in this case) a service is being quitted by the provider, the HFA must within three months of the notice of quitting have developed a consultation plan. Given this obligation, HFA Wellington would have had good grounds to seek a time extension (if this was necessary).

2.017 In our view, HFA Wellington should have undertaken a process of consultation as required by the *Purchasing Handbook*. Because there was no consultation, HFA Wellington had no input from interested parties as to the suitability of either:

- the service as specified in the RFP documentation; or
- the service it has contracted WIPA to provide.

2 In fact, the HFA is under a statutory duty to consult – section 34, Health and Disability Services Act 1993.

2.018 We also think that the failure to consult was an underlying cause of the problems in the later parts of the process to contract a new provider.

The RFP Process

2.019 The *Purchasing Handbook* outlined the RFP process as requiring:

- Preparing the RFP document and advertising for proposals.
- Evaluating the proposals.
- Selecting a preferred provider and negotiating with that provider to finalise details of the service to be provided.

2.020 The RFP documentation stated that the service included:

- provision of assessment, diagnosis, treatment and ongoing management of sexually transmitted diseases (STDs) including HIV/AIDS;
- personal health education/promotion activities;
- referral/liaison with a full range of community, health and welfare services; and
- national health status surveillance activities.

Evaluation Criteria

2.021 The documentation also stated that, in evaluating proposals, HFA Wellington would consider the following factors:

- credibility and competence of proposed staff and management experience in the provision of clinical services;
- philosophy of care;
- ability to provide the full range of services;
- provision of equitable services for the whole Wellington region;
- price proposed and financial viability of the proposal; and
- cost-effectiveness.

2.022 The *Purchasing Handbook* stated that the evaluation criteria should be set out in the RFP, and that the relative importance of the criteria may be indicated. The RFP did not indicate the relative importance of the factors listed above.

2.023 In our view, the "criteria" in the RFP were so broadly framed that it would probably have been difficult to assign them an order of importance.

Service Inclusions and Exclusions

2.024 The RFP documentation said that the service to be provided included:

- a laboratory diagnostic service; and
- a contact tracing service.

2.025 Excluded from the service to be provided (because they were purchased under other arrangements) were:

- primary medical consultations;
- family planning consultations;
- pharmaceuticals; and
- public health promotion services.

Other Information

2.026 Other information given in the RFP was that the budget for the service was about $800,000 (excluding GST), and the deadline for receipt of proposals was 12 February 1999 (later extended to 19 February 1999).

Evaluating the Responses

The Evaluation Process

2.027 Seven providers submitted proposals in response to the RFP.

2.028 A panel of four HFA staff evaluated the responses. The criteria that the panel used are not immediately recognisable as the factors stated in the RFP documentation (see paragraph 2.021) and they:

- were considerably more detailed; and
- were developed after the RFP was issued.

2.029 The evaluation "criteria" in the RFP were topic headings rather than explicit criteria and, as such, were too general to provide much assistance to potential providers. If HFA Wellington had developed its actual evaluation criteria before issuing the RFP – and included them in the RFP together with an indication of their relative importance – providers would have had a better guide as to how to frame their bids.

2.030 HFA Wellington asserts that the evaluation criteria it used were "an elaboration" of the factors in the RFP.

2.031 The total evaluation score available was 200. The four top-scoring short-listed proposals scored as follows:

WIPA	153
Family Planning Association	152
Healthcare Aotearoa	148
Hutt Valley Health Limited	136

Conclusions

2.032 In our view, the evaluation process was compromised in part by:

- HFA Wellington not determining the precise evaluation criteria and their relative importance until after the RFP had been issued; and
- consequently, potential providers not knowing what the precise criteria were.

2.033 Subject to that qualification, HFA Wellington applied a proper method of evaluation and was able to identify four possible providers.

Interviews of the Short-listed Providers

2.034 The evaluation panel interviewed the four short-listed providers over the period 10-12 March 1999. The providers had been written to and asked to discuss specific matters relating to their proposal, including:

- geographic coverage;
- sites;
- availability/accessibility;
- high-risk sections of the population; and
- price/volume information.

2.035 HFA Wellington told us that the purpose of the interviews was for it to:

- ensure that it had understood the providers' proposals;
- clarify any points;
- test the credibility of the providers; and
- give providers the opportunity to answer or rebut any issues identified with the proposal.

2.036 At the interviews the providers outlined their proposals in general terms and then responded to specific issues raised by the panel. The specific issues varied according to the matters that HFA Wellington wanted to discuss with each provider in relation to its proposal.

2.037 We interviewed three of the providers for their perspective on this process. They considered that they had received a fair hearing from the panel, but gained the impression that

HFA Wellington was looking for a different service from that specified in the RFP.

2.038 We were concerned with the suggestion that the panel may have approached its task with a different service requirement in mind to that specified in the RFP documentation, so we raised our concern with HFA Wellington.

The HFA's Interview Rationale

2.039 Paragraphs 2.040-2.048 set out HFA Wellington's response to our concern. It was able to produce little in the way of formal documentary support for the response.

2.040 HFA Wellington was seeking cost-effective proposals for delivering a specialist sexual health service. Some of the key cost-effectiveness and philosophy of care issues for treatment of STDs were:

- Only about one-third of people with an STD were attending the specialist sexual health service. Of the remainder, 50% went to a GP and the rest went to another primary care provider – Family Planning or Student Health Services – even though the specialist service was free and GPs and Family Planning usually were not.
- Only a minority (estimated at 20%) of the people currently using the Wellington sexual health service required the specialist expertise of a secondary service.
- Treatment at an STD clinic for the most common STDs cost the HFA about $130 a consultation, while treatment by a GP cost the HFA about $35 plus laboratory tests. Therefore, every time someone who did not require specialist expertise was seen by the STD clinic there was a net cost to the HFA of more than $80 for no appreciable health gain. If the person went otherwise untreated because of financial barriers, numerous other costs were incurred to the person's health, to society, and to the HFA.
- GPs were not considered to be very well trained in best practice for assessing and treating STDs (as supported by recent research on treatment of chlamydia).

2.041 At the interviews the panel asked questions relating to these issues because an important element of cost-effectiveness was the appropriate targeting of the specialist service to:

- complex or high-risk cases who require specialist attention; and
- those who would otherwise go untreated (such as low-income people, sex industry workers, and people unwilling to use GP services).

2.042 A further consideration was that the contract HFA Wellington had with CCH was for 4,324 first consultations and 4,444 follow-up consultations annually. At the latest count, CCH was providing 4,793 first consultations and 11,781 follow-ups. The HFA was not paying for the excess of follow-up consultations because of the capped nature of the contract. If the contract had not been capped, the HFA estimates that this would have cost it an additional $300,000 a year.

2.043 The HFA saw the ability to control the volume of specialist consultations as a very important consideration in terms of the cost-effectiveness of proposals. Its view was that, to ensure cost-effectiveness, it was essential for providers to have an appropriate philosophy of care – in particular, a philosophy that emphasised and supported treatment at the primary level wherever possible.

2.044 It was this mix of considerations that lay behind the questioning of the providers. HFA Wellington was concerned to establish that each provider correctly understood:

- the proposed number of people to be treated (which was not always clear from the proposals);
- how volume risks would be covered; and
- the cost-effectiveness of the proposed service.

2.045 Given that the RFP stated that *the HFA was seeking to purchase the best value service within the available funds*, HFA Wellington expected the providers to have addressed the issue.

2.046 Using the supplementary information obtained at the interviews, HFA Wellington analysed the costs of the respective proposals and compared these costs (including the cost of laboratory testing) with the providers' expectations

of the number of visits to a specialist health service. The results are shown in Figure 2.1 below.

Figure 2.1
Comparative Costs of the Short-listed Bids

	Family Planning	WIPA	Healthcare Aotearoa	Hutt Valley Health
Annual Price*	$1,147,254	$900,000	$870,000	$850,000
First Consultations	4,000	4,800	2,825	3,600
Follow-up Consultations	4,000	7,200	8,475	4,000
Total Consultations	8,000	12,000	11,300	7,600
Cost per Patient	$286.81	$187.50	$307.96	$236.11
Cost per Consultation	$143.40	$75.00	$76.99	$111.84

*Including the cost of laboratory testing.

2.047 The analysis showed that WIPA had the most cost-effective proposal as well as having the highest score in the formal evaluation process (see paragraph 2.031). WIPA was therefore selected as the preferred provider, although the reasons were not documented.

2.048 HFA Wellington is adamant that the interviews were conducted with an open mind and that it was not seeking a service different to what was specified in the RFP.

2.049 HFA Wellington telephoned WIPA on 15 March 1999 to advise it of the decision and to request a meeting the next day. The other three providers were advised in writing that their bids were not successful.

Our View

2.050 It is possible that the questions the evaluation panel put to the providers relating to the issues described could have been misunderstood to mean that a different service was being sought.

2.051 HFA Wellington, in its concern to obtain the best value service, appeared to apply detailed criteria that the providers responding to the RFP could not have anticipated clearly from the RFP documentation with which they were supplied. Documentation making HFA Wellington's rationale clear would have aided potential providers – perhaps including providers that did not respond to the RFP – in formulating their responses so as to match the HFA's expectations.

2.052 The *Purchasing Handbook* emphasised the importance of documenting all decisions. The reasons for selecting WIPA were not documented – we obtained them by interviewing HFA Wellington staff. This was a specific deficiency in the final evaluation.

Finalising the Service to be Purchased

Negotiations with WIPA

2.053 At the meeting with WIPA on 16 March 1999, HFA Wellington:

- confirmed that it was the preferred provider;
- raised the possibility of sub-contracting parts of the contact tracing service to Hutt Valley Health;
- discussed options for purchasing laboratory services; and
- raised the possibility of making the specialist service more cost effective by improved targeting – which, in HFA Wellington's view, could be achieved by making it easier for people to be seen in primary care.

2.054 WIPA became concerned that it was being asked to provide a service beyond what was specified in the RFP. Such was its concern that (immediately after this meeting) it sought legal advice on whether HFA Wellington could depart from the RFP. The legal advice given to WIPA was to the effect that, because a clause in the RFP reserved the right of HFA Wellington to negotiate with a provider on any matter relating to the service, then it was able to vary the service specifications.

2.055 In our view (as discussed in more detail later), the service specifications for the specialist sexual health service remained, with one exception, much the same. However, combining in one contract the ***specialist*** sexual health service and a new ***primary care*** service created a different service to that described in the RFP.

2.056 Following the meeting of 16 March 1999, both WIPA and HFA Wellington carried out some cost modelling on the various options to see whether the cost of the specialist sexual health service could be reduced and more people could be treated in the primary sector.

2.057 After several more meetings, it was concluded that – to ensure that more people were treated in the primary sector, with the specialist service treating only those actually in need of specialist treatment – an additional patient subsidy for primary health consultations would be needed. The subsidy would allow for free consultations for the diagnosis and treatment of STDs and for free contraceptive consultations.

2.058 The main elements of the new service therefore would be:

- Provision of a reduced specialist sexual health service.
- The HFA would meet the direct cost of laboratory testing services. The RFP said that the provider would have to meet this cost in the first instance. However, the uncertainties associated with establishing the true cost was a major concern for providers because, if actual costs proved to be much higher, the provider would bear the additional cost.
- WIPA would administer a scheme under which the HFA would pay a new patient subsidy for GPs to provide free consultations on matters relating to sexual health and contraception. The free consultations would be available to young people. All GPs and the Family Planning Association are able to participate in this scheme. This new subsidy is expected to cost the HFA $560,000 a year. The RFP said that family planning and GP consultations were excluded from the service to be provided.
- WIPA would run training programmes for GPs wishing to provide this service. The training programmes would aim at improving the knowledge of GPs in the diagnosis and treatment of STDs.

The Service Being Purchased

2.059 The total annual cost of the service being purchased from WIPA is $520,000 – comprising $500,000 for the specialist health service and $20,000 for administering the free primary service.

2.060 The total annual cost to the HFA of the new service (excluding laboratory testing[3]) is $1,080,000 – comprising $520,000 paid to WIPA and $560,000 for the new patient subsidy.

3 Estimated by CCH to be $240,000 a year.

2.061 The HFA is bearing the cost of laboratory testing because of its expectation of a reduced demand on the specialist service. This expectation is predicated on the free GP consultations for young people for sexual health and contraception reducing the number of people with an STD using the specialist service. HFA Wellington also expects that providing guidelines to GPs on the tests that are necessary will reduce the number of unnecessary tests and, thus, the overall cost of testing.[4]

2.062 The HFA has described the new service as helping *to remove artificial divisions between sexual health and reproductive health.* This will be achieved by reducing the specialist service and increasing the free primary service through accredited GPs. The free primary service will include free contraceptive advice and free consultation and diagnosis of sexually transmitted diseases. By integrating a sexual health service with a reproductive health service, the HFA aims to reduce the number of unplanned pregnancies and reduce the incidence of STDs.

Conclusion

2.063 The new sexual health service being provided in Wellington is significantly different from the "specialist" service for which the RFP was issued.

2.064 In our view, an equal opportunity should have been afforded to all potential providers to bid for this revised service. At the least, HFA Wellington should have allowed the four short-listed providers the opportunity to bid for the revised service.

2.065 Arguably, however, had HFA Wellington purchased the first proposal from WIPA – i.e. the provision of a specialist sexual health service as specified in the RFP – any question of unfairness would not have arisen.

4 HFA Wellington has told us that tendering for the provision of laboratory testing has resulted in a reduction to the unit price paid for tests.

Other Matters

Approval of the Purchase

2.066 Internal HFA procedures require that a Purchase Board – consisting of senior HFA staff – must approve all purchasing decisions for amounts over $100,000. The Purchase Board is required to ensure that purchasing decisions are supported by robust analysis. The Purchase Board approved the purchase of the WIPA service on 31 March 1999.

2.067 We reviewed the paper putting the purchase of the new service to the Purchase Board. The paper described in detail the service to be purchased, but it did not describe in any detail the process followed to select WIPA as the preferred provider.

2.068 From the summarised information provided in the paper, the Purchase Board would not have been able to determine that it was being asked to approve the purchase of a service that was significantly different from that described in the RFP. Consequently, it could not have been aware that there was a significant issue of fairness in the process followed.

Conflict of Interest

2.069 Our guide *Good Practice for Purchasing by Government Departments* includes a guideline that staff involved in purchasing decisions must declare any personal interest that may affect – or could be perceived to affect – their impartiality in carrying out any aspect of their work. We interviewed HFA staff about their declaration of any personal interests. We also reviewed files and spoke with staff from the providers that had submitted proposals.

2.070 None of the HFA staff that we interviewed who were involved in the purchase of the service had any personal interest such that it would have been necessary for them to declare it. We did not find that any external influence had been brought to bear to appoint a particular provider.

Contents

Summary

In late-1998 the Auckland Office of the Health Funding Authority (HFA Auckland) sought proposals from a range of potential providers of forensic post-mortem services in the Auckland region. Proposals were received from three providers. HFA Auckland selected the proposal from Auckland Healthcare Services Limited (Auckland Healthcare).

Clinical Support Solutions Limited (CSS) was part of a joint venture which had submitted an unsuccessful bid. CSS considered that an unfair process had been used to select Auckland Healthcare, and asked the Audit Office to review the process. Some of the concerns raised by CSS appeared sufficiently serious to warrant our review, which we undertook in February 1999.[1] Our conclusion is that the process by which HFA Auckland evaluated proposals and selected a provider of post-mortem services was fair and careful.

HFA Auckland assessed the proposal from Auckland Healthcare as best meeting the specifications for the services. It was also, by a wide margin, the most cost-effective proposal.

HFA Auckland had some difficulties in providing in a timely manner information to all of the potential providers. However, all of the information sought was provided before the closing date for receipt of proposals.

Nationally, the HFA now has a manual that should ensure an ability to demonstrate that purchase arrangements reflect best practice.

1 We made a report of our review to HFA Auckland in May 1999.

Introduction

3.001 In October 1998, the Auckland office of the Health Funding Authority (HFA Auckland) sought proposals from interested organisations to provide forensic post-mortem services in the Auckland region. After evaluating the three proposals received, that from Auckland Healthcare Services Limited (Auckland Healthcare) was chosen.

3.002 Auckland Healthcare is the largest provider of health services in the Auckland region and operates Auckland, Greenlane, National Women's and the Starship Children's Hospitals.

3.003 One of the proposals was submitted by the New Zealand Institute of Forensic Pathology Limited (NZIFP). NZIFP was a joint venture between Clinical Support Solutions Limited (CSS) and Te Runanga O Ngati Whatua (the Runanga). When the NZIFP proposal was not selected, CSS sought a review by HFA Auckland of the purchase process it used. When HFA Auckland rejected this request, CSS asked us to carry out a review.

3.004 In view of the detailed nature of the concerns that CSS raised, and to ensure that proper processes had been followed, we decided to review the adequacy of the procedures applied. We did so in our capacity as auditor of the HFA.

Background

3.005 Under the Coroners Act 1988, a coroner has the power to decide whether or not a post-mortem to establish cause of death should be performed and, if so, to instruct a pathologist to conduct the post-mortem. In the Auckland region there are approximately 1,500 forensic (or coroner-directed) post-mortems each year. Four forensic pathologists employed by the Auckland Medical School carry out these post-mortems.

3.006 The Auckland Medical School held the contract with HFA Auckland to provide forensic post-mortem services. A May 1998 report on the School's mortuary by the Occupational Safety and Health Service (OSH) found that the facility was well below the requirements of the Health and Safety in Employment Act 1992. Rather than try and upgrade the facility, the School decided to quit the service. The School needed the space occupied by the mortuary for other uses, and decided that provision of forensic post-mortem services was not part of its core business.

3.007 The School advised HFA Auckland in June 1998 of its intention to quit the service. The School was agreeable to carrying on the service until July 1999, with the new provider leasing its facility from that date until 30 June 2000. By the latter date the new provider was expected to have found other premises from which to provide the services.

3.008 During 1997-98 the Government had also been reviewing the funding arrangements for forensic post-mortem services for the whole country. It decided that from July 1999 the purchase responsibility would transfer from the HFA to the Department for Courts.

3.009 Consequently, HFA Auckland had to:

- Ensure continuity of the services in the short term by obtaining the co-operation of both OSH and the Auckland Medical School to continue to use the School's mortuary.

- Find a new provider to provide, as from July 1999, coroner-directed post-mortem services. The new provider would also have to find new premises as from June 2000.
- Ensure a smooth transfer of responsibility to the new purchaser, the Department for Courts, as from July 1999.

Selecting the Preferred Provider

3.010 We compared the process used to select the new provider of forensic post-mortem services against two sets of benchmarks:

- the HFA's procedures for the purchase of a service (dealt with in paragraphs 3.011-3.019); and
- the guidelines relating to fairness of process in our own publication *Good Practice for Purchasing by Government Departments* (dealt with in paragraphs 3.020-3.058).

The HFA's Process

3.011 HFA Auckland did not have formal guidance by way of documented procedures for issuing the *Request for Proposals* (RFP) to seek responses from potential providers. Staff explained that they would use the RFP approach for only a very small number of the contracts they issued. Rather, they assessed a wide range of RFP documentation from other HFA offices and used parts of that documentation as models for the purpose of this contract.

3.012 Under the previous regional health authority structure, each division of the former Northern Regional Health Authority (North Health) was highly specialised and had differing purchase arrangements. Hence, there was no common approach to purchasing. This situation should change with the adoption of common purchasing practices resulting from the creation of the HFA and its implementation of a new purchasing manual.

3.013 HFA Auckland staff accepted that the requirements for the forensic post-mortem services were poorly defined. In developing a service description, they had to start from scratch because no documentation was available in their office

that would have assisted in preparing the RFP. However, there were extensive discussions with potential providers to define the service required and the process to be followed in calling for proposals from providers.

3.014 One document that is relevant to all purchases made by HFA Auckland is an agreement signed in April 1995 between North Health and the Runanga. The agreement (still current) commits HFA Auckland to consult at an early stage with the Runanga and to involve the Runanga (as a co-purchaser) in all planning, purchasing, and monitoring decisions affecting Maori health. The agreement also provides that the Runanga has agreed not to exercise its co-purchaser role where there is a conflict of interest – for example, where it is the provider of a specific health service.

3.015 On 1 October 1998, the Chief Executive of the Runanga sent a fax to the Maori Health Locality Team of HFA Auckland, saying:

> *It has been brought to the attention of the Runanga that there is to be a meeting of iwi health officials convened at your offices at 1.30pm on Friday, 2 October 1998 to discuss the future of mortuary services provided through Auckland Healthcare. Further, I am given to understand that you may be calling for expressions of interest at the meeting. The Runanga, either through its provider operation or its co-purchaser organisation has not received formal advice from your office and is unable to be represented at the meeting by either myself or a Runanga official because of other commitments.*

3.016 The Chief Executive of the Tihi Ora MAPO – the co-purchaser arm of the Runanga – had been invited to the meeting of 2 October 1998 and attended the meeting.

3.017 The meeting went ahead without the Chief Executive of the Runanga present, but with the Chief Executive of the Tihi Ora MAPO present. A review of the correspondence between HFA Auckland and the MAPO shows that, by inviting the MAPO Chief Executive to the meeting of 2 October 1998, HFA Auckland believed that the correct consultation process was being followed. The Runanga has indicated that neither HFA Auckland nor the MAPO formally informed it of the process. HFA Auckland and the Runanga later had discussions on the matter, and HFA Auckland has told us that:

This difference of opinion between the HFA and the Runanga has been addressed by the parties in order to ensure that operational protocols, including effective communication, are clarified in order to continue the successful and mutually beneficial relationship between the HFA and the Runanga via the MAPO.

Conclusion

3.018 HFA Auckland staff involved in preparing the RFP went to considerable lengths to specify a process to be followed, even though no documentation was available to them in their office that specified the process to be followed.

3.019 Standard documentation to guide all HFA staff should now be available through the new HFA purchasing manual.

Being Fair in the Process

3.020 We tested the process used for the purchase of forensic post-mortem services against the benchmarks in our guide *Good Practice for Purchasing by Government Departments* relevant to the fairness of the process for inviting proposals to provide the services.

Declaration of Interests

3.021 Staff involved in purchasing should declare any personal interest that may affect, or could be perceived to affect, their impartiality in carrying out any aspect of their work.

3.022 The first meeting of the evaluators to discuss their evaluations of the proposals received was on 12 November 1998. However, because not all evaluators had completed their evaluations, the meeting was adjourned until 19 November 1998.

3.023 At the second meeting on 19 November 1998, a conflict of interest was identified – one of the evaluators was employed by one of the parties submitting a proposal.

3.024 To handle the conflict, HFA Auckland agreed that the evaluator concerned would not participate in the process for scoring each proposal. However, that evaluator would still provide an analysis of each proposal, which would be made available to each of the other evaluators.

Conclusion

3.025 A conflict was identified, and HFA Auckland devised a way of dealing with it. However, if all of the evaluators had completed their evaluations in time for the meeting of 12 November 1998 – before the conflict was recognised – a decision could have been made which may have been challenged at a later date because of the conflict of interest. This highlights the need for clear policies and procedures that allow for an early declaration of any conflicts of interest.

Procedural Fairness

3.026 A strong theme of our guide *Good Practice for Purchasing by Government Departments* is the need to ensure the fairness of the purchase process. In its complaint to us, CSS pointed to two actions by HFA Auckland that in its view suggested that the process in this case was not fair.

3.027 First, at the meeting of 2 October 1998, HFA Auckland staff handed out a draft service specification for comment. CSS representatives were not at this meeting, as it was essentially a meeting of Maori health leaders – except that Auckland Healthcare staff attended. CSS suggested that giving Auckland Healthcare an early opportunity to review and comment on the specification gave the latter an unfair advantage.

3.028 The minutes of the meeting of 2 October 1998 record the consultant to the HFA as also asking whether it was appropriate for staff from Auckland Healthcare to comment on the draft documentation, given that Auckland Healthcare could be tendering for the service. The Auckland Healthcare staff present at the meeting gave assurances that they were commenting as Maori, not as Auckland Healthcare staff. Following this meeting, the Change Management Analyst at Auckland Healthcare wrote to HFA Auckland on 5 October 1998 expressing thanks for allowing *Maori Health Management, Auckland Healthcare the opportunity to participate in discussions on the future provision of Post Mortem Services and to comment on draft service specifications.*

3.029 While it may be possible to read too much into this comment, it appears from that letter that the Auckland Healthcare staff who attended the meeting might indeed have seen themselves as representing Auckland Healthcare. In this sense, there could be a perception of unfairness in the process. That is, if a draft service specification is to be circulated for comment – including comment from the staff of one of the potential providers – then it should be made available to all interested parties. Nevertheless, in this case the draft specification was circulated to all parties several days later.

3.030 Secondly, CSS expressed concern that one of the forensic pathologists at the Auckland Medical School had assisted in writing the service specification even though (CSS understood) the pathologist may also have had a part-time

appointment with Auckland Healthcare. In fact, all of the forensic pathologists at the Auckland Medical School assisted with the preparation and clarification of the service specification. No-one else had the necessary knowledge about how forensic post-mortem services in Auckland were provided.

3.031 Forensic pathology is a highly specialised branch of medicine. Of the five forensic pathologists in New Zealand, four work at the Auckland Medical School. Of necessity, HFA Auckland had to rely on the forensic pathologists at the School for an accurate description of the services being provided.

Conclusions

3.032 In our view, it was reasonable for HFA Auckland to seek the assistance of the forensic pathologists in preparing the service specification.

3.033 Handing out the specification to a meeting attended by staff from one of the potential providers could have been perceived as providing an unfair advantage to that provider. However, the draft specification was circulated to all parties several days later.

3.034 In our view, the fact that one potential provider received the draft specification several days before other potential providers would not have altered the final outcome in this case.

General Requirements for Specifications

3.035 Our guide *Good Practice for Purchasing by Government Departments* recommends that:

> *Specification documents should be clear, concise and accurate so that they can be understood by all parties having an interest in them.*

3.036 CSS questioned the adequacy of the information in the service specification. In particular, it questioned whether the information in the specification was sufficient to allow a full costing of the service.

3.037 The RFP documentation contained the following pricing information:

Volumes: *The expected number of coroner-directed post-mortems in the Auckland area is 1,500 per annum. The annual price may be reviewed if volumes increase or decrease by more than 7.5% per annum.*

Price and Term: *Please note that if the proposal meets the Health Funding Authority and Department for Courts criteria, it is our policy to offer a contract at a base price for a minimum period of three years after which the price will be reviewed.*

3.038 CSS asserted that this level of information was insufficient to prepare a response. It sought a meeting with the forensic pathologists in order to ensure that it had all the relevant information. This meeting was held on 28 October 1998 and all respondents to the RFP were present. Arising from this meeting, the following additional information needs were identified:

- costs associated with the tissue donation service;
- amount of out of hours work;
- a list of the equipment held by the Auckland Medical School; and
- workload levels of the histology service.

3.039 This information was provided to all potential providers on 30 October 1998. Also on 30 October, arrangements were made for respondents to inspect the mortuary at the Auckland Medical School. The successful tenderer would need to operate at this mortuary for 12-18 months before transferring to a new building and one of the respondents had pointed out that they had not been allowed to view the existing facility.

3.040 Forensic pathology is a clinically and culturally complex specialist service. Developing an appropriate service description was not easy and – while aspects of the service specification were detailed – respondents believed that there was insufficient detail on service levels to properly cost their proposals. All the required information was provided

– although most of the additional information requested relating to equipment was not available until the evening of Friday, 30 October 1998 (five days before the deadline for submitting proposals).

3.041 HFA Auckland considered that the service specification contained all the necessary information. Nevertheless, it was not until respondents were able to question the pathologists and view the mortuary that they became aware that they needed additional, crucial information to complete their costing.

Conclusions

3.042 Forensic post-mortem services are complex. HFA Auckland sought to provide all necessary information, but the need for some further information was not identified until just before the deadline for receipt of proposals.

3.043 This suggests that – when seeking proposals for the provision of health services, and particularly complex services – meetings should be held at an early stage between potential new providers and the staff currently providing the service to ensure that all information needs are identified. This step should be incorporated in the formal documented policies and procedures.

Evaluation of Proposals

3.044 Our guide *Good Practice for Purchasing by Government Departments* stresses the importance of a sound evaluation process for assessing proposals. It suggests that:

> *The people appointed as evaluators should bring to the task the required technical and (in most cases) legal knowledge and experience as well as the ability to make a balanced judgement and avoid any suggestion of bias. The task of evaluation is often big enough to justify an evaluation panel. In this event, the work of the panel can be better served if the requisite skills are spread amongst the members. The membership of the panel could also be varied for different aspects or stages of the evaluation.*

3.045 Items to be included in the evaluation criteria are also suggested, including:

- *the need to address compliance with the specification; and*
- *the need to enable, for more complicated evaluations, meaningful "weightings" or relative values to be assigned to different features, together with a method for combining weightings for ranking purposes.*

3.046 HFA Auckland followed this evaluation process:

- A panel of evaluators was appointed – including people with cultural, financial, legal and technical evaluation skills.
- Each evaluator was provided with a copy of each proposal, which was not identified by the name of the provider.
- Each evaluator was also provided with a copy of the evaluation score sheet, which they completed in isolation from the other evaluators.

3.047 The evaluation score sheet had the following seven categories:

Quality of Service. Evaluators had to score protocols, accreditation, safety standards, service provision, and complaints.

Staffing. Items included experience of staff, cultural awareness, qualifications, and management team.

Management Structure. Items included reporting lines, accountability, subcontracting arrangements (laboratories, etc), board composition, and ability to monitor and provide reports.

Acceptability. Items included Coroner, Police, cultural, religious, sensitivity, Hospital/University.

Facility. Items included safety standards, size and capability, national referral centre status, accessibility.

Location. In relation to laboratory services, radiology, and key interest groups.

Viability. Items included operational, financial, guarantees, price, contract term, facility costs.

3.048 Weightings were applied to each category.

3.049 The result of the scoring was that Auckland Healthcare outscored CSS and South Auckland Health in all but one of the categories (where CSS outscored the other contenders).

3.050 As part of the evaluation process, HFA Auckland sought the views of an overseas forensic pathologist. He reviewed all three proposals and considered that the Auckland Healthcare proposal best met the requirements set.

3.051 After selecting the Auckland Healthcare proposal, HFA Auckland entered into discussions with Auckland Healthcare to clarify details of its proposal. In particular, clarification was sought on how Auckland Healthcare was to demonstrate improved cultural awareness, evidence of religious and cultural sensitivity, and several other matters.

3.052 CSS argued that this demonstrated that Auckland Healthcare did not meet many aspects of the tender criteria. However, the RFP document made it clear that acceptance of a proposal did not mean that a contract would be entered into. Auckland Healthcare's proposal was selected as the superior of the three but, in HFA Auckland's view, it needed more work before a contract was signed. We consider that to be an acceptable approach.

Conclusions

3.053 HFA Auckland undertook a rigorous and fair evaluation of the three proposals received. The process was well documented and resulted in the selection of a preferred provider. As is recognised practice, HFA Auckland entered into negotiations with Auckland Healthcare before signing a contract.

Briefing Unsuccessful Tenderers

3.054 Our guide *Good Practice for Purchasing by Government Departments* suggests that it may be appropriate to explain to unsuccessful tenderers why their proposals were not successful. Such a briefing should focus on the evaluation of the proposal. This course of action is suggested in order to lessen the possibility of discouraging bids for future purchases. We see a healthy response to purchasing proposals as ultimately in the public's best interests.

3.055 After selecting Auckland Healthcare, HFA Auckland telephoned the unsuccessful bidders to advise them of the outcome.

3.056 Following this telephone call, CSS asked HFA Auckland to review the process by which it selected Auckland Healthcare. CSS was told that such a review was not necessary as *Auckland Healthcare emerged as a very clear leader over and above the other two respondents who scored relatively equally, but a long way behind Auckland Healthcare.*

Conclusions

3.057 Rather than just a telephone call, a briefing of CSS would have clarified the fact that CSS did outscore the other contenders in one area and that CSS did score well on some of the other evaluations.

3.058 As a rule, briefing unsuccessful tenderers would assist them to understand why their bids were unsuccessful and how future bids could be improved. This may also assist in encouraging a healthy response to future purchase proposals.

Background

4.001 Health Benefits Limited (HBL) is wholly owned by the Health Funding Authority (HFA). HBL was formerly owned by the Transitional Health Authority (THA) as successor to the original owners – the four Regional Health Authorities.

4.002 HBL's main role is to process and pay claims for Government health subsidies, and to provide information and compliance services to its owner and other clients. Claims for payment of subsidies on pharmaceuticals dispensed by about 1,000 community pharmacies are processed at its Wanganui Centre (HBL Wanganui).

4.003 The manual system of processing subsidy claims involves pharmacists sending the prescriptions from which they have dispensed medicines to HBL Wanganui for the processing and payment of any subsidy and other associated costs. Pharmacies claim every fortnight. Each year about 35 million pharmaceutical items are processed for subsidy claims.

4.004 Staff at HBL Wanganui have to read each prescription and manually enter the details into a computer system. The computer system checks the details and calculates the price of each item and the amount to be paid to the pharmacist.

Our 1997 Investigation

4.005 In 1997 several pharmacists complained to the Audit Office about problems they had experienced receiving timely and accurate reimbursement of their claims for pharmaceutical services subsidies from HBL.

4.006 We investigated these complaints in August 1997 and found the complaints to be justified. Among other things:

- We found that HBL had a backlog of queries resulting from over 10,000 unpaid claims by pharmacists.
- HBL said that it would clear the backlog by late-December 1997, but in our view that would be impossible given the average time being taken to resolve each query.

- We saw faults in the way in which HBL was processing repeat prescriptions.
- We indicated that we would carry out a follow-up review at an appropriate time.

4.007 The full report of our investigation was included in our *Fourth Report for 1997*.[1]

4.008 HBL's processing problems were in part due to the change to monthly dispensing from three-monthly dispensing of medicines (a policy decision made by the then four Regional Health Authorities) which placed HBL's manual systems under intense pressure. HBL told us that the problems of manual processing we had highlighted would be overcome with the introduction of electronic claiming of pharmaceutical benefits.

What We Looked At This Time

4.009 The purpose of our follow-up review was to find out what had happened about clearing the backlog of queries and settling the outstanding claims.

4.010 We expected to find that:

- HBL and/or the HFA would have settled all 10,300 claims unpaid in 1997 – or a settlement timetable and amount would have been agreed; and
- the great majority of current queries were being actioned within the contracted time of 20 working days (see paragraph 4.021).

Clearing the Backlog of Unpaid Claims

4.011 HBL, the HFA and the THA had known of the problem of the backlog of unpaid claims for some time. For completeness, it is necessary to recount briefly the history of the attempts to resolve the problem.

4.012 In May 1997, the Pharmacy Guild of New Zealand (the Pharmacy Guild) – which represents most community pharmacists – raised the backlog of unpaid claims with the

1 Parliamentary paper B.29[97d], pages 61-75.

THA. The THA passed the problem (along with several other related issues the Pharmacy Guild had raised) to HBL to resolve.

4.013 HBL told us in August 1997 that the backlog – which then amounted to 10,300 queries – would be cleared by December 1997. However, by February 1998 the backlog had in fact grown to 11,300.

4.014 The Pharmacy Guild again expressed concern about the need to resolve the problem and HBL assured it that:

- a large number of initiatives had been taken to improve the processing of claims; and
- the backlog would largely be cleared by June 1998.

4.015 But on 31 July 1998 HBL told the Pharmacy Guild that the backlog of queries still numbered 10,200 and that it would take another six months to clear.

4.016 By October 1998 the backlog had increased slightly to 10,700. HBL concluded that it would not be possible to resolve this number of queries and that there would have to be a cash settlement – for which it devised a method (based on a statistical sample) to calculate the amount owed to each pharmacy.

4.017 Responsibility for negotiating the settlement with the Pharmacy Guild rests with the HFA because it has the direct contractual relationship with pharmacists.

4.018 The HFA and HBL worked on a proposed settlement over the next three months and the HFA put a proposal to the Pharmacy Guild on Christmas Eve 1998 – requesting it to respond by 22 January 1999. The Pharmacy Guild responded by that deadline, although it had reservations about the terms of the settlement.

4.019 Substantive meetings between the Pharmacy Guild and the HFA did not take place until May 1999 and eventually agreement was reached on the methodology to be applied to establish the amount required to settle the outstanding claims.

4.020 The agreement – formalised in a *Memorandum of Understanding* dated 4 June 1999 – records that:

A number of pharmacy reimbursement claims are outstanding (unpaid) following the return to monthly dispensing in May 1996. The parties share a desire to resolve the matter.

Agreement has been reached that the Guild will manage settlement of these reimbursement claims for all pharmacies and advise the HFA on the settlement figure for each pharmacy within a total figure of $1.25 million (GST exclusive). The settlement is a full and final settlement that includes:

- *the full price for all unpaid claims for the period 1 October 1996 to 30 June 1998;*
- *compensation for any errors in the claims data pertaining to that period;*
- *the interest cost incurred by claimants due to the time that has passed from the date of the claim to the date of settlement.*

Current Situation

4.021 The new Pharmacy Contract between the HFA and pharmacists (signed in October 1998) requires HBL to respond to pharmacists' queries within 20 working days. This requirement came into effect from 1 January 1999. HBL reports indicate that almost all queries are being actioned within 20 days.

4.022 About the time the new Pharmacy Contract was being signed the Board and management of HBL had become increasingly concerned with the performance of the claims payment process. Consequently, the General Manager engaged a management consultant to examine the process. The consultant reported in February 1999, identifying a number of operational deficiencies.

4.023 HBL took steps to remedy those deficiencies, which was achieved through:

- technical improvements to the systems hardware and operating environment to make the hardware more reliable;
- providing staff with productivity reports; and
- introducing a query management system to allow a more systematic approach to handling queries.

4.024 The Pharmacy Guild has worked with individual pharmacists to calculate the outstanding amounts due to them. Initially, all but 26 pharmacists agreed to the settlement, and they followed an appeal process. On 2 August 1999 the Pharmacy Guild sent the HFA details of the agreed payments, and on 10 September sent details of the final settlements for the 26. The overall cost of the settlements to the HFA is within the agreed $1.25 million. The HFA expects to make the payments by the end of September 1999.

Conclusions

4.025 As a result of system improvements at HBL Wanganui, nearly all current queries are being processed expeditiously and there is no new backlog of queries and outstanding claims.

4.026 The 1997 backlog stemmed directly from the decision of the four Regional Health Authorities to change to monthly dispensing in May 1996. As HBL acknowledges, the change was introduced without it or pharmacists having sufficient time to be prepared for the consequences.

4.027 When the difficulties created by the backlog became evident, HBL was slow to realise that it could not resolve the problem. In our view, the near-impossibility of working through such a huge backlog should have been evident to HBL. Instead, HBL gave assurances that it could resolve the problem.

4.028 The HFA sought to reach agreement to pay pharmacists for their outstanding claims. An amount estimated as being due to each pharmacist has been calculated. Almost a year since HBL concluded that a cash settlement would be necessary the pharmacists are about to be paid.

4.029 It is not clear to us why a settlement has taken so long.

Lessons to be Learned

4.030 In our view, two lessons need to be learned from this situation:

- The HFA and HBL need to be more cautious about implementing major policy changes affecting operating

systems. They should first test the proposed changes – carefully assessing all impacts and ensuring that sufficient time is allowed for implementation – before entering into new performance commitments.

- HBL management should assess problem areas more carefully before giving assurances that they can be resolved. Factors to be considered include resource levels, the capacity to fix problems, and alternative means of resolution. In this case HBL was too optimistic – it set deadlines for resolution that it did not meet, and finally had to admit that it was unable to resolve the problem.

4.031 Failure to learn those lessons would put the credibility of both the HFA and HBL at risk.