Prepared for the Accident Compensation Corporation

Alliance contracting: background and relevance for ACC funded services

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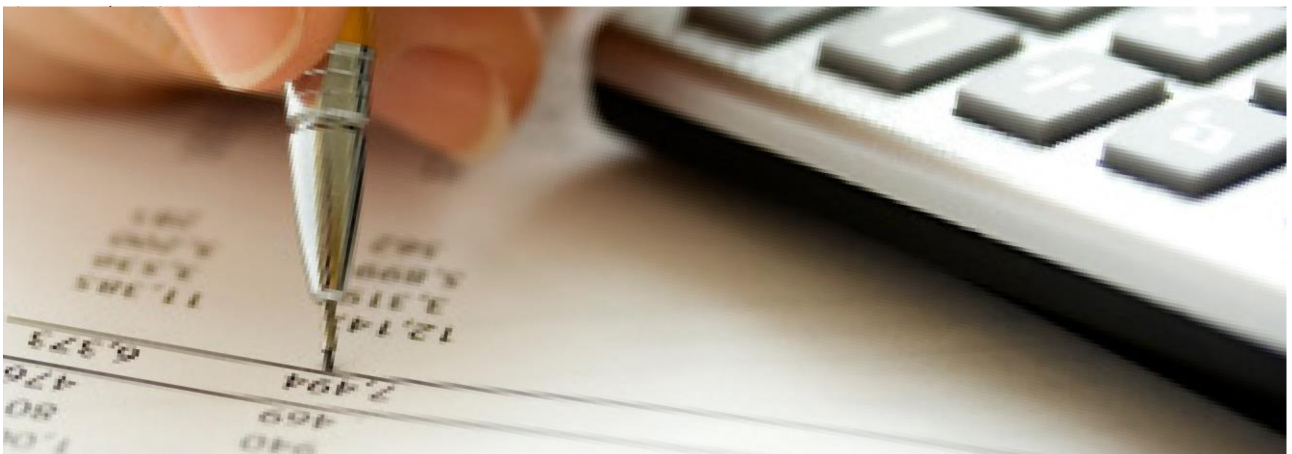

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Executive summary

This paper has been commissioned by the Accident Compensation Corporation to provide background for informed discussion about the use of alliance contract approaches for ACC funded services. On the basis of documentation, interviews and personal experience it presents the background and recent experience of alliance contracting in the New Zealand health sector. It identifies that key risks arising from alliancing include:

- Deadlock, where agreement cannot be achieved, and the scope of the alliance is unclear;
- Reduced accountability, where a service funder shares decision making;
- Ineffective implementation, where service design is not followed up by adequate operational management;
- Anticompetitive behaviour, where alliance participation is not transparent.

The gains which can be expected from alliance contracting include:

- Innovative and responsive service design;
- Stable relationships among stakeholders;
- Improved risk management arising from common ownership of service risks; and
- Capacity building and access to expertise

These gains do not follow automatically from alliance implementation. In order to achieve them participants must work systematically to agree the scope of their alliance and the resources available for service development, and must engage in good faith to have effective working relationships with each other. Coaching and facilitation has been an important component of a number of successful health alliances. Experience of health alliances in New Zealand has been variable, but in many cases there have been positive results, with innovative service development and effective service integration.

The greatest gains from use of alliances are likely to come where there are complex service challenges involving a range of different organisations and professional groups. When working well, alliances can work as a mechanism for bringing the relevant professional and management experts together to address complex service issues, and to achieve consensus from the relevant stakeholders about a way forward.

1. Introduction

This paper has been commissioned by the Accident Compensation Corporation to provide background for informed discussion about the use of alliance contract approaches for ACC funded services. It considers:

1. The background for the development of alliance contracting internationally and in the New Zealand health sector;
2. Recent experience of alliances in the New Zealand health sector, including two brief case studies;
3. What opportunities exist for ACC in pursuing alliance arrangements for some of its services; and
4. What risks, opportunities and obstacles ACC might face in pursuing alliance contracting for some of its services.

This paper draws upon background papers about alliancing development from the Ministry of Health, the personal experience of the authors in working with health alliances, and a series of interviews with participants in health alliances across New Zealand. There has been no formal evaluation of alliancing since it was developed in the context of New Zealand health services in 2010, so the material presented in this report represents a small scale informal evaluation of some aspects of alliancing, and derives some key lessons from the experience of alliance participants.

2. Background

2.1 The theory

The difficulty of coordinating individuals or groups with diverse interests is a longstanding theoretical problem in philosophy, political science and economics. The problem has formed the basis of a substantial interdisciplinary literature analyzing both theoretical and empirical aspects of the issue. Applications of the collective action problem affect approaches to agreements and collaborations in ecology, natural resources, infrastructure, social services and international relations.

A classic analysis of the issue, which has been the starting point for much subsequent analysis, sets out the problem of the "tragedy of the commons". Hardin analyzed the problem of collective action in the context of land enclosures and population pressures, and pointed out that short term rational interest formed a basis for different parties to use natural resources for individual gain, but that this runs counter to a common long term interest in maintaining the sustainability of the resource. Hardin contended that balancing these interests was in general not susceptible to a formal technical or regulatory solution (Hardin 1968)

Key recent academic commentators on problems of collective action include:

- Elinor Ostrom, who argues that shared mutual understandings between players can produce rational decisions to manage resources in the joint interest, and offers a number of theoretical models of reciprocity and cooperation (eg. Ostrom 1998, Ostrom 1999);
- Ernst Fehr, who argues that reciprocity is an important enforcement device in incomplete contracts, analysed particularly in the context of employment contracts (Fehr 2000). In collaboration with others, Fehr has provided both theoretical argument and empirical evidence that long term relationships of mutuality between contractual parties, in the absence of third party enforcement, can result in greater gains for both parties (Brown et al 2004);
- Joel Sobel, who argues that actors often operate from a basis of intrinsic reciprocity, rather than a purely instrumental reciprocity based upon maximizing individual outcome (Sobel 2005).

In a health sector context, this problem can be seen as an issue of individual professional or organizational interests trumping a common overall interest in improved services or better outcomes for a population. Health services are complex, frequently involve many different parties, are difficult to specify clearly in terms of linked inputs, outputs and outcomes, and are beset by information asymmetry between professionals, patients and funders. The problem for funders and providers of health services is therefore to find a mechanism which allows a balance between a wide range of individual interests and perspectives, and the overall goal of providing efficient, effective services. Much of the work on integration of health services over the last decade, both in New Zealand and overseas, can be seen as attempts to address some of these issues.

2.2 The application

Alliance relationships are likely always to have existed in some business environments, but have become an explicit object of inquiry only recently. Much of the recent commentary on alliances, both as governance arrangements and as contracting mechanisms, has been published by Reuer and Arino, who have analysed contractual designs. They distinguish between alliance governance and alliance contractual arrangements, which are related but not necessarily a one to one relationship, and note that there has been little systematic research on alliance contracting as a process and the outcomes which go beyond the legal document involved (Arino 2004). Alliance governance is useful when there are important

'spillovers' or externalities from the project for the different organisations involved (Baker and Murphy, 2002).

Strategic and contractual commercial alliances have been developed in many sectors, including telecommunications (Kashlak et al 1998), biotechnology (Zhang et al 2007, Robinson and Stuart 2007), energy (Gebauer and Segev 2000) and infrastructure (Turner 2001, MacDonald 2012). Alliances in the infrastructure sector, particularly communications or engineering infrastructure, begin to raise issues of state involvement as an alliance partner. This is the starting point for the field of public private partnership (PPP) design, in which the issues of managing risk sharing and trust in a complex long term project are key for state and private partners.

Davies, in a postgraduate thesis, characterizes commercial alliance arrangements as having:

- Unanimous decision-making protocols;
- A commercial arrangement where there is no recourse to the courts for dispute resolution; and
- A remuneration system where the contractor and principal share cost overruns and underruns.

Davies identifies a number of benefits of alliances in the context of public sector projects, but also a number of risks, including the absence of price competition, the potential for new fiduciary obligations, the absence of recourse to courts, the risk of deadlocks, and issues with liability and insurance. He concludes that alliances bring risks, but that many of these risks already exist in conventional procurement mechanisms, and that they can be modified if price competition is introduced into the alliance mechanism. His view is that alliances are appropriate for delivering outcomes in the public sector where there are high project risks, and where competition is limited (Davies 2008).

Project alliances are based on clearly understood principles to which all participants are fully committed. A project alliance is typically founded on the following generic principles:

- All participants win, or all participants lose, depending on the outcomes actually achieved;
- The participants have a peer relationship where each has an equal say in decisions for the project;
- Risks and responsibilities are shared and managed collectively, rather than allocated to individual participants;
- Risks and rewards are shared equitably among the participants;
- All participants provide 'best-in-class' resources;
- The participants are committed to developing a culture that promotes and drives innovation and outstanding performance;
- There is a clear definition of responsibilities in a no-blame culture;
- All transactions are to be fully open-book; and
- Communication between all participants is open, straight and honest.

In New Zealand, the New Zealand Transport Authority has been a practitioner of alliance arrangements in the procurement of complex infrastructure projects, and currently uses alliance partnerships for the Waterview tunnel project in Auckland, the Mackays to Peka-Peka roading project, the State Highway 16 Causeway in Auckland, the Auckland Motorways Alliance, and the Wellington Tunnels Alliance, among others. NZTA uses a competitive process to select alliance partners, and to establish that alliance groups are able to work together in the necessary relationship of trust and collaboration.

2.3 Establishing alliances in the New Zealand health sector

2.3.1 Better sooner more convenient projects

The first formal use of alliance arrangements in the New Zealand health sector arose from the nine "Better Sooner More Convenient" (BSMC) business case projects, established in 2010. The Ministry of Health worked to develop an alliance contracting process as the underlying contracting structure for the activities of the nine projects. The rationale was that each project group involved a number of different players, that their goals were complex, and that cooperation between the different professions and provider organisations would be a vital pre-requisite for the successful delivery of integrated services.

The Ministry used an open process to develop the alliance structure, based upon a small advisory group involving representatives from health professionals, primary health organisations and District Health Boards. The proposals of the advisory group were workshopped with two larger groups of sector stakeholders.

The Ministry's overall goal in using alliances is to promote clinical leadership in the health system, with aligned clinical and financial accountability and supporting clinically led decisionmaking. The approach to achieving this, in an alliance context, is intended to be the promotion of integrated resource management, with decisions about health care services being made jointly by all of the relevant professional and organizational parties.

Health alliances are usually structured as follows:

- A district alliance, operating across the geographic area of a district health board, and involving the DHB as service funder, and clinical leaders from key services. In the majority of cases leaders appear to come from hospital and general practice services, but in some cases involvement in the leadership team also comes from other professions, such as pharmacy, and physiotherapy, or other services such as community NGOs;
- Participants agree to work together to achieve services which are best for patients and best for the health system as a whole. Participating organisations agree to bring the relevant resources for services within the scope of the alliance to the table, and to work in an open book fashion with their alliance partners;
- The District Health Board, via its planning and funding function, sits on the alliance leadership team. This reflects the DHB's role as a planner across the system (and the expertise and resources in planning which it can bring to the alliance table). It also reflects the statutory responsibility for planning services which cannot formally be devolved from the DHB;
- The scope for the alliance was originally set by the range of service developments proposed in each group's Better Sooner More Convenient business case. The participating organisations have the ability to agree wider scope for the decisions of the alliance should they wish to do so;
- Service alliances are convened as necessary, to address specific issues, and to involve particular stakeholders or expertise for a given area. The scope of service alliances is determined by the overall district alliance;
- The District Health Board, as the funder of most services within the alliance scope, agrees to contract for those services according to the directions of the alliance. This is a moral commitment, rather than a legally enforceable one, since the DHB cannot devolve its statutory responsibilities under the Health and Disability Act. However the bar for a DHB to contract other than as directed by the alliance is high, and would almost certainly represent a failure of information sharing, trust and the long term relationships which underpin the alliance;
- District alliances do not constitute a new legal entity, and are reliant for operations upon the legal, contracting, analytical and other resources of their participants.

This process resulted in a template for a contract which states the commitment of each organizational party to the District Level Alliance. This contract is not for services, but for participation in the alliance mechanism, and specifies:

- The scope, activities and objectives of the alliance;
- How decision rights will be allocated across different parties, including government agencies, and how the process for joint decisionmaking will work where applicable;
- Principles for working together;
- The roles and responsibilities of the alliance leadership team;
- Arrangements for joining and leaving the alliance; and
- Dispute resolution.

There has been no formal evaluation of the functioning of the nine alliances established for the better sooner more convenient projects. There is a widespread perception that their effectiveness spans the range, from the dysfunctional to the highly capable. At least one of the original nine alliances has disbanded and reformed itself since 2010. At least one of the alliances has broadened its scope and successfully used alliance processes for a wider range of service decisions.

2.3.2 2013 PHO contracts

In 2013 the Ministry of Health undertook a significant renegotiation of the national basis of the primary health organisation (PHO) contract. The parties to these contracts are DHBs and PHOs across New Zealand, who had input into the contract negotiations via the PSAAP process. The 2013 negotiation resulted in a requirement that all DHBs and PHOs develop alliance relationships.

The Ministry specifically defines the role of a District Alliance as to:

- provide leadership within a health community;
- assess needs of populations;
- plan and design health services in a district at a high level, including decisions about prioritization;
- establish, set goals for, and monitor service alliances;
- identify opportunities for evolution and service development;
- identify the need for work streams and service level alliances; and
- problem solve.

The Ministry reports that alliances have now been established in all districts, and is actively providing support for alliance leadership where coaching and facilitation is required.

2.3.3 Other relevant health sector alliances and organisations

Alliance arrangements have been used in other ways within the health sector. These include:

- South Island District Health Boards, which use an alliance approach for working together on regional goals and services;
- Whanau Ora collectives have formed across New Zealand in response to Te Puni Kokiri's Whanau Ora development programme. It is not clear how many of these collectives are using alliance arrangements in a formal sense, but some of these projects are likely to take a form of governance which comes close to a formal alliance;

- Specific service alliances exist, which may or may not lie within the overall structure of district alliances required by the Ministry of Health. One example is the B4 Schools Check alliance in Auckland, which involves the Auckland District Health board, Plunket and ProCare in an alliance with the specific goal of increasing the level of pre-schoool health checks.

There are six social sector trials across New Zealand, which involve lead agencies managing a programme of work using cross agency resources. These arrangements have some similarities to health alliances, but use a fundamentally different underlying structure, with a national Joint Venture Board at agency chief executive level, with a contractually responsible individual or agency and an intersectoral advisory group. The emphasis is much more upon high level national agency commitment and leadership than upon local control over decisionmaking.

The language of alliancing appears to have become common currency in some parts of the health sector, and a variety of relationship arrangements are increasingly referred to as alliances. It is likely that these will actually encompass a wide range of circumstances, some of which may not be genuine alliances in the sense of full sharing of risk and resources for a specific goal.

2.3.4 Discussion

Health alliances in New Zealand originally developed as a mechanism to support the integration anticipated in the nine Better Sooner More Convenient business cases. The model was initially suggested by alliancing arrangements in the construction industry, on the grounds that these approaches managed to combine a strong focus upon collaboration and joint resource management, while respecting the commercial imperatives of the parties involved. In a health sector which combines government agencies, NGOs and private commercial entities (particularly general practice, which lies at the heart of the BSMC business cases groups), these properties were seen as strongly desirable.

But while the starting point for the health alliancing model was derived from infrastructure alliances, the model evolved to address a number of specific issues and situations which were important in the health sector. These were:

- The statutory requirements of District Health Boards as funders. Because DHBs are not able to devolve their statutory responsibilities for planning and funding services, they cannot undertake a full legal commitment to sharing resource decisions. Health alliances therefore acknowledge that DHBs have reserved powers, but provide a strong balance to DHB power via the alliance leadership team, and set a high bar for DHBs to act unilaterally against the direction set by the alliance;
- Designing the District Alliance as a permanent entity rather than a project based entity, and providing for membership to change, acknowledging the need to address commercial and competitive issues should new parties emerge who seek to participate in the alliance. Some commercial alliances have a very long term focus, but the majority, particularly those in the infrastructure sector, are project based rather than permanent;
- Providing for Service Level Alliances with specific scope underneath the District Level Alliance, to coopt additional expertise as necessary when addressing particular service development issues, and to widen the connection with stakeholders while retaining a focused group at the Alliance Leadership Team level;
- While variation in the particular form was permitted, alliances in the New Zealand health sector have been mandatory for the relevant parties – firstly the nine better sooner more convenient business case groups, and latterly all PHOs and DHBs. This is significantly different from the case in private industry and infrastructure procurement, where alliances are voluntary groups which self select on the basis of ability to collaborate;

Several commentators distinguish between alliances as governance arrangements, and alliances as contractual agreements. While the term 'alliance contracting' has gained currency in the New Zealand health sector, the main focus of alliances lies upon building the relationships between parties necessary to make complex decisions about managing resources in health care. While an alliance contact exists, which participants of an alliance leadership team will sign, that contract concerns good faith participation in the alliance, and the behavior which is expected of an alliance partner. Service contracts remain between funder and provider, although their content and structure is determined by the alliance.

The goals of using alliances in New Zealand healthcare are somewhat different from the typical goals of a commercial alliance, which are predominantly about risk management and alignment of complementary resources to achieve the best return possible for the parties. Health alliances were developed with the explicit aim of embedding clinical leadership into debate about health services and the best use of healthcare resources. The essential aspect of an alliance is that it is a mechanism for achieving a consensus about service development which cuts across the specific interests of individual professions and organisations.

3. New Zealand experiences

3.1 Approach

We conducted a rapid scan of alliances in the New Zealand health sector, and interviewed a number of key informants, who were selected to have experience which spanned a range of alliance arrangements and roles. Informants are listed in Appendix One. We asked informants about their experiences of alliances, views on what made alliances a success or failure, and where they felt there might be gain for ACC in using an alliance approach.

We summarised material from two examples of alliance activity to demonstrate how alliances work in the New Zealand health sector.

3.2 Themes from informant interviews

Alliance development

Lessons have been learned about alliance development from groups across New Zealand. We found a high degree of consistency from informants on most themes around alliance development, although a variety of views on the effectiveness of mandatory alliances (by contrast with voluntary alliance partners). Main points are:

- Alliances are a very local solution, and their particular makeup and way of functioning can vary widely. This is likely to be a key aspect of the permissiveness which is fundamental to local trust and relationship building. A time period of years is needed in order to achieve full maturity;
- The experience in health alliances has been that many groups were initially hesitant, and that in some cases management, particularly in DHBs, were reluctant to engage. In some cases, where groups didn't take part at the beginning, the lack of coverage undermined the effectiveness of the alliance;
- Strong leadership and organizational commitment is very important, with capacity to devote the time and resources to the alliance a key success criterion. This issue also manifests itself in the greater ease with which organized groups of professionals, particularly general practice, find it easier to engage with alliances than professions with less history of organisation, including a number of allied professions;
- Once established, alliances have in some cases been able to drive change and innovation quickly, with more flexibility to respond to emerging situations than other service development approaches. Alliances have been successful, in at last some parts of New Zealand, in promoting integration and achieving faster progress on integration than was previously possible;
- The Ministry of Health form of alliance contract, which expresses the commitment of partners to the alliance process, is sometimes criticized as excessively legalistic and formal;
- Establishing who should, and who should not, be a member of an alliance leadership team is often a contentious and difficult issue. This can sometimes be the starting point for revealing differences of opinion and exposing the areas where relationships need to be developed;
- Not all alliances have worked well. Some have struggled to identify a clear scope, and have become embedded in process rather than engaging with substantive issues. Clarity of scope and mutually respectful relationships are at the heart of alliance success, and when these are absent, the risk of failure or lack of productivity is high;

- Lack of flexibility in resources or information, for example as a consequence of the use of price volume schedules within DHB hospital services, is sometimes seen as a barrier, but some informants viewed this as more an issue of perception than reality. Where there is genuine commitment, there is an incentive to find ways of making funding mechanisms fit for purpose, rather than perversely distorting services;
- A number of informants suggested that alliance development can evolve rapidly, and risks resulting in "project management for Africa", and "meetings for meetings' sake". Stakeholders can sometimes find the capacity needed to participate in an alliance daunting, and small or less organized communities or professions can struggle to support the workload involved. Discipline is needed to manage the unchecked proliferation of project management and meeting workload.

Scope

All informants emphasized the importance of clear scope of alliance decision making. This has implications in several ways:

- Clarity of scope reflects the common goal which the participants have agreed to address together. Lack of clarity about scope probably indicates incomplete communication between participants, and should be a warning that work will be needed to improve mutual understanding and consensus across the participants;
- Scope defines resources, so agreeing the scope of services determines what service resource will be available for reconfiguration, and makes clear what commitment the different participants have to the alliance. For example, if the scope is diabetes services, the matching resource available for reconfiguration and service development should probably cover existing diabetes services within a PHO, general practice consultations, specialist diabetes nurses, and hospital based outpatient diabetes services. If participants are reluctant to contribute the resources, then this is a sign that there is a lack of common understanding and commitment. While there might be risks for individual parties, a genuine alliance commitment will mean that they will work to find a direction which has gains for all parties;
- An appropriate scope for an alliance should address a complex service, with a number of different professions and organisations involved. A simple scope, involving one profession, or where the preferred approach is obvious and uncontested, is unlikely to see much in the way of additional gains from using an alliance process; and
- In defining the scope of an alliance, it is important to consider metrics for establishing the ongoing success for the alliance, and to be clear about where the alliance is adding value to services for patients and the health system.

Relationships

Nearly all informants felt that establishing good working relationships was essential to alliance success. In some cases they saw the relationships which have developed in an alliance context as a positive development in itself, and a success in overcoming a long history of antagonism. The strong emphasis in health alliances on clinical participation and clinician design of services has helped to break down silos and barriers between professionals. One informant expressed it particularly clearly:

> *There is trust – and decisions are respected and implemented. No one challenges them. If the Alliance makes a decision, then people will work with it.*

It is often felt that alliance participation helped to "take away revenue drive and perverse incentives", allowing people to focus on the substantive issue of designing better services. Consumer and community representatives can play an important role in helping to engage people, so that change is less challenging to implement, and also in asking hard questions of professionals, and challenging professional

perspectives. Alliances are predominantly, in the eyes of many people, an organizational framework for identifying and working towards the common value.

However in some cases there were anecdotes in which participants sometimes could not get over historical paranoia, and one informant suggested that those who were disengaged before the alliance have become even more disengaged over time. In this case the alliance has ended up polarizing people who are not like minded.

Even in a successful alliance, there are ups and downs in relationships, and bumps in the road. This is generally viewed as inevitable, and part of the broader challenge of trying to address difficult and complex problems. The role of the DHB can often be a challenging aspect of alliance relationships. In some cases the DHB, because it retains a statutory role for planning and funding decisions, can be seen as dominant and an unequal partner. But this dynamic can work in other ways, and an alliance can also operate as a way of holding a DHB to account for commitments.

Incentives, competition and compulsion

One controversial aspect of alliance development has been the mandatory nature of alliances, first as the compulsory form for BSMC business case groups, and more recently as the required form of relationship between PHOs and DHBs. This is one of the fundamental differences in the way health alliances have developed in New Zealand, by contrast with the traditional approach in infrastructure procurement in which alliance collaboration is established among voluntary partners who compete, as an alliance, to demonstrate their capacity to achieve the goal.

Some informants felt that the mandatory alliances in New Zealand, in cases where the parties were not yet ready to work together, have achieved very little. But others pointed to a number of achievements, and argued that, with effective coaching and facilitation, reluctant alliance partners could form relationships of trust. Recent discussion between the Ministry of Health and the primary care sector has established that the role of alliances facilitators is very welcome, and highly valued by participants. Ongoing organizational development and coaching is clearly particularly important where alliances are mandatory rather than self selected. Some informants suggested that mandatory alliances, in which participants are forced to dip their toe into new arrangements, can bring benefits and engender change where other mechanisms cannot. This is supported to some extent by one informant who said:

> *We might not like the final arrangement that much, but we'd rather be there at the table than not be there at all.*

By contrast, other informants felt that this was not the case at all, and that competitive incentives to collaborate voluntarily, as is traditionally the case in the infrastructure sector, are a sounder approach. The jury is still out on the effectiveness of mandatory alliance arrangements.

Alliances in the infrastructure and other sectors can have a formalized gainshare/painshare risk sharing agreement between the commercial participants. This forms the incentive to achieve efficiencies and bring the project to a successful conclusion. Some health alliances see financial risk sharing as an important component of their arrangement, and it should be noted that the original development of alliances was inspired in part by the need for government agencies to find a better way of working with private commercial entities including general practices. But in many cases the incentive to participate is predominantly the professional incentive of designing a better service for patients, and making clinical work easier, less bureaucratic and more effective. The commitment of the DHB, as the funding partner for alliances, was in itself a part of the incentive to participate in an alliance for some primary health organisations.

3.3 Example one: laboratory services

Goals

The goal of the Canterbury laboratory alliance was to develop integrated lab services. The background to the alliance is that the Canterbury earthquake in 2011 had made existing laboratory facilities unusable, while at the same time community laboratory contracts were coming up for renewal. All parties perceived an opportunity to change, reconfigure and improve community laboratory services. Two private community laboratories existed in the market, and the DHB's own hospital laboratory provided services to hospital clinicians, and had an interest in extending its range of service to the community.

Stakeholders and resources

Stakeholders included the DHB planning and funding arm, managers and clinicians from the hospital laboratory and the two incumbent private community laboratories, and stakeholders including general practitioners as referrers, and a consumer representative. The resources available were the existing community laboratory budget of CDHB.

The solution

The alliance identified a preferred configuration for community laboratory services, consisting of one hospital laboratory and a single community laboratory provider. The role of the alliance was explicitly to identify preferred service configurations, and not to manage contracting processes, which remained the role of the DHB.

The DHB consulted on the preferred approach, and then used an RFP process to choose the single community laboratory provider. There was some controversy during the transition of services to a single community lab provider, but the decision was not challenged, and the change was successfully implemented.

The lab alliance continues to lead integration in lab services. The alliance meets on a four weekly basis and serves as a forum for raising issues between the two laboratories remaining in the market. Examples include IT and pathology information systems, courier and collection centre configurations.

Comment

This is an alliance process with a broad goal, but a clearly defined scope of services. The market for community referred laboratory services is a vigorous, commercial and competitive environment, and attempts to reconfigure laboratory services in other parts of New Zealand have been controversial and subject to litigation. In this case, the alliance process ensured that the preferred service configuration was based upon the advice of clinicians and stakeholders, and that clinical and patient perspectives formed a clear, defensible rationale for the preferred solution. A history of difficult relationships between a number of stakeholders has been overcome, and while a robust commercial model has been used by the DHB to contract for the services, the two laboratories currently in the market actively use the alliance process to continue the agenda of integration and service improvement.

3.4 Example two: deep vein thrombosis

Goals

In Wairarapa deep vein thrombosis was being managed predominantly through presentation to the emergency department, where patients would receive clexane injections. A clinical audit established that there was scope to provide the service safely in a community setting for a significant proportion of patients.

The goals of this alliance activity were to:

- Reduce the rate of attendance at ED of Triage 5 patients waiting to have clexane injections;

- Reduce the avoidable hospitalisation rate; and
- Provide a free service to patients which is timely and convenient.

Stakeholders and resources

The participants in the project included general practice, an ED medical officer, DHB and primary care pharmacists, and project managers. The District Alliance allocated resource from an underspend elsewhere in the system, in this case from an underspent after hours budget.

The solution

The project identified a need for:

- Training for GPs;
- Support resources in practices and the DHB (including access to ultrasounds);
- Stock management of clexane, managed by the DHB;
- A simple claiming process to support free attendances in general practice;
- Development of a budget; and
- Evaluation.

Comment

This is a relatively small and discrete example of alliance activity, but the fact that it operated within the overarching Better Sooner More Convenient alliance meant that it was straightforward to identify some funding which could be reprioritized for the project. Although relatively small, it is a service which has involvement from a wide group of clinicians, including medical practitioners, radiology services and pharmacists in both hospital and community settings, and is therefore potentially complex in terms of service response. The alliance process facilitated a clinically driven redesign of the service, and the funder and provider organisations involved did what was necessary to implement that design. The scope of the project was very clearly defined, and the alliance participants had clear, measurable goals.

4. Risks and opportunities

4.1 Application

Alliances, as they have been implemented in the New Zealand health sector, are a variant of commercial alliances, and have important differences from typical commercial arrangements. Some see this as a strength, while others see it as a weakness. The most effective application of alliances is in situation where:

- There are multiple parties involved in a complex service (but not so many as to make the alliance unwieldy);
- There is a shared problem or challenge which is perceived by all parties;
- There is a strong desire to promote clinical input into service development;
- There is a clearly defined scope for the breadth of alliance decisionmaking;
- Participants are able to commit to sharing resources for the common goal; and
- There is time and capacity on the part of the participants to commit to the alliance process, and support it.

While some argue that mandatory alliances can't work and that competitive alliance selection is important for success, there is some evidence that with the right support and commitment, mandatory alliancing can result in functional service development, even where the original relationships are not promising. Alliance coaching and organizational development are essential even in a voluntary alliance, and particularly so in a mandatory one.

It should be noted that there are circumstances in which alliances are not appropriate. Where there are not multiple professional or organizational parties involved, or where the solution to a problem is relatively clear and uncontroversial, the added value of an alliance may be small.

4.2 Risks and mitigation

Alliance arrangements come with a number of risks for the parties involved:

- *Deadlock*: If scope is unclear or effective working relationships do not develop, alliances can become stuck in circular process around defining their scope without addressing the substantive service development issues. In the event of deadlock, an alliance can chew through time and other resources while achieving little or nothing. This risk has been mitigated in some cases by effective alliance coaching and facilitation;
- Reduced accountability for resources: From a funder's perspective, committing to use resources in a way directed by the alliance could mean reduced accountability for the management of health resources. This risk is mitigated by being clear about the scope of services which will be covered by alliance decisions, while the contractual mechanism for service funding remains between the funder and provider. While on the face of it alliancing may dilute accountability for managing funding because of the number of people involved in decision making, from another perspective it can work to broaden the accountability for managing funding, as a range of stakeholders share the funder's challenges;
- Ineffective implementation: Alliance groups can engage in effective service design, but there remain risks around implementing changes effectively. If an alliance has achieved consensus about a preferred service model, then implementation must be well resourced and monitored, and the alliance should take ownership of successful development beyond the strategic stage. An operational alliance management team typically reports to the Alliance Leadership Team and is responsible for ensuring that implementation is well executed. A barrier to implementation

can arise if there is insufficient mandate from partner organisations, resulting in relitigation of an alliance's decisions; and

- Anticompetitive behavior: Alliances can risk becoming closed shops, and engaging in anticompetitive behaviour which is at the very least inefficient and may have the potential to be illegal. This risk can be mitigated by ensuring that, for a given service design, the actual selection of providers is open and competitive, and by careful selection of members of an alliance leadership team. Joining an alliance, where appropriate, must be an open and transparent process.

4.3 Gains

There are three specific aspects in which alliances can generate gains:

- Innovative service design: Involving a number of stakeholders with different perspectives, and ensuring that clinical voices are heard in service design, can result in new approaches to funding and delivering services. This has been demonstrated in a number of circumstances across health services in New Zealand. Alliances can sometimes use their flexibility to work more quickly than other service development processes;
- Stable relationships: Alliances can be the mechanism to promote stable relationships between stakeholders, both clinicians, managers, service consumers and their respective organisations. An alliance can serve as a forum where issues can be safely raised and resolved, with less acrimony and resentment than is sometimes the case in relationships between funder and provider organisations;
- Risk management: Risk is ever present in health services, whether financial risk, continuity risk or clinical risk. Sharing responsibility for service configuration across all alliance partners can help to manage some risks, particularly financial and continuity risks. If a funder cannot contract out of their duty to ensure service coverage, then mitigating the risk of service failure or discontinuity provides a significant gain; and
- Capacity building and access to expertise: People with the relevant expertise for effective service development can be spread across multiple organisations and professions. The use of an alliance approach means that service development can draw upon the best available people for advice, regardless of organisational or professional boundaries.

5. What are the opportunities for ACC?

[Redacted]

6. Discussion

Alliances applied to health services in New Zealand are a distinctive model. The approach has been based on aspects of commercial sector alliances, but in this form has become more focused upon alliancing as a mechanism for achieving consensus on integrated service development, particularly in areas where the system is complex, and there are a number of different parties, professions and organisations which need to work together. While the term alliance contracting has become widely used, contracting per se is not the principal focus of existing health alliances: the priority is effective service design, which can then be implemented with whatever contractual mechanism is appropriate. The alliance contract is an agreement to participate in good faith with the other parties to the alliance.

Some aspects of alliance contracting are, nearly four years down the track, beginning to become clear. The importance of clear scope definition and relationships of mutual respect appear to be widely recognized, and the value of alliance coaching and facilitation to help participants through difficult relationships and complex issues is generally agreed. Alliances have demonstrably been successful in facilitating clinically led service design in a number of areas. But the value of imposing alliances upon reluctant parties is controversial, with arguments and some anecdotal evidence on both sides of the issue.

Alliances can bring risks, including risk of failure and wasting resource and time. To some extent alliances can bring risks of diluted accountability, but these risks have generally been managed by DHBs in health alliances, and in many respects alliances can be seen as a tool for helping DHBs to manage risks by involving a range of stakeholders in the challenge of designing sustainable services.

ACC operates in a number of areas in which there are complex relationships between a number of professions involved in service development. These are very much the kinds of services where alliances have the potential to bring gains. Alliances are likely to bring value to ACC in circumstances where:

- It is possible to define a clear scope of service for alliance decision making;
- There are a number of different parties and/or professions involved in service provision, requiring coordination and agreement on best service configuration;
- There is value, such as reduced duplication, increased effectiveness or better targeted resource, to be gained from agreeing service configuration with other partners;
- There is a clear mutual interest between ACC and potential alliance partners.

We have suggested a number of areas where some of these criteria apply, and there may be benefit from a more formal analysis in order to prioritise areas where alliancing might bring value. ACC faces a number of statutory constraints upon its funding and accounting processes. But these need not necessarily be a major impediment to alliance development. Since the alliance approach is predominantly focused upon service integration, specific contractual structures are not dictated. The issue may be that ACC lacks the flexibility to support some service configurations with appropriate funding mechanisms, but this issue can be put to the test, and part of the challenge of alliance partnership may in itself be to address such constraints.

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Appendix: Interview informants

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- Anne O'Connell, Manager Primary Care, Ministry of Health
- Carolyn Gullery, GM Planning and Funding CDHB, Canterbury Clinical Network Alliance Leadership Team
- Vince Barry, CEO Pegasus
- Dr Iain McCormick, Executive Coaching Centre
- Ken Stewart, physiotherapist, Canterbury Clinical Network Alliance Leadership Team
- Liz Baxendine, Consumer Representative, Canterbury Lab Alliance
- Dr Neil Hefford, GAIHN Alliance Leadership Team
- Paul Roseman, manager ProCare,
- John Baird, Independent chair, GAIHN
- Michael Playle, Policy Manager, ACC
- Dr Peter Gootjes, Southern Community Laboratories
- Gina Lomax, Injury Prevention Manager, ACC