

OFFICE OF THE MINISTER OF HEALTH

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

DISTRICT HEALTH BOARDS AND THE NON-GOVERNMENT HEALTH SECTOR

PROPOSAL

1. As part of the process to establish District Health Boards, this paper proposes guidelines for the relationships between DHBs and other parts of the health sector. An explicit policy on these relationships will assist DHBs as they make arrangements for service funding and delivery in the new environment.

EXECUTIVE SUMMARY

2. Currently more than half of total public spending on health and disability support services goes to providers that are not government-owned. For many types of providers (eg rest homes or GP organisations) there are no publicly-owned alternatives at present. DHBs will therefore be heavily dependent on non-government providers to deliver publicly-funded services other than secondary care. There will also be instances when it may make sense to allow privately-funded services to be delivered in a DHB facility.
3. However when DHBs choose providers for public services or consider an involvement in private provision, there are a number of risks. These include the risk that private hospitals, having been paid to treat public patients, will have to refer complicated cases back into a DHB facility; or that public patients will miss out if private patients have access to DHB facilities. This paper proposes protocols to address these risks and guide DHBs in making arrangements for service funding and delivery.
4. For publicly-funded services, I propose that the paramount consideration should be that the provider chosen is the most effective option to achieve gains in health and independence for New Zealanders and close gaps within available funding. Other guidelines are proposed including one to ensure that DHBs observe Treaty principles and continue to build the capacity of Maori providers and another to guard against poor decisions arising from conflicts of interest. The Provider Selection Protocols are set out in Annex 1 with examples given in Annex 1A.
5. For DHBs to be involved in the provision of privately-funded services, I propose that first and foremost, there needs to be a direct benefit to public patients. By this I mean that private involvement would need to lead to an improvement in the clinical quality or the efficiency of a service for public patients. There must also be residual capacity after first serving public patients, and an adequate level of publicly-funded service. Other guidelines are proposed to ensure transparency, avoid conflicts of interest, and limit the range of services that can be offered

privately by a DHB provider. The Private Involvement Protocols are set out in Annex 2 with examples given in Annex 2A.

BACKGROUND

6. One of the fundamental principles underpinning our health policy is that it is a core responsibility of government to fund and provide a safe, high quality, effective, and comprehensive public health system. The Government is committed to ensuring that, regardless of ability to pay, all New Zealanders have access to an acceptable level of health and disability support services when they need them.
7. Currently the public health system relies on a wide range of providers, some publicly-owned and some privately or community-owned. The Government remains committed to maintaining the quality and range of services that are provided by its own Hospital and Health Services. However, where a better health outcome will result, we should always be willing to consider moving services to a non-Government provider (eg a Maori provider of health promotion services).
8. For many types of providers (eg rest homes or GP organisations) there are no publicly-owned alternatives at present. This paper addresses the role of non-Government providers in delivering publicly-funded services. It also considers under what circumstances privately-financed health services may have a place in publicly-owned facilities.
9. The table below shows that the simple public/private distinction often made in Health is in fact a lot more complex.

Examples of how services are currently funded and provided

	Government provision	Mixed provision	Non-government provision
Public funding	Hospital inpatient & outpatient services Laboratory services for hospital inpatients & outpatients	Maternity inpatient services (often involves self-employed midwives)	Community laboratory services GP services & pharms for under 6s Rest home & long-term hospital care for the elderly with few resources
Mixed funding	DSS - use of aids & equipment Hospital-based dental services for children & low income adults needing immediate treatment	Maternity services at Cornwall Suite, National Women's (free clinical services & extra amenities for a charge)	GP services for adult CSC holders Pharmaceuticals for over 6s DSS - Caregiver support
Private funding	Some elective surgery & diagnostic procedures (under previous Govt's private patient protocols)		GP services for adult non-CSC holders Most dental services Significant amount of elective surgery Rest home & long-term hospital care for the elderly with sufficient resources.

CURRENT ARRANGEMENTS

Publicly-funded patients in private facilities

10. In March I released a strategy for reducing waiting times for public hospital elective services. Among other things, this provides for publicly-funded surgery and specialist assessments to be provided in private facilities to manage peak demands and as an interim measure to reduce backlogs of patients. The strategy requires available public capacity to be used first, and public disclosure of the contracts with private providers.

Privately funded patients in public facilities

11. If an HHS wanted to treat private patients, the previous Government allowed it do so subject to a set of “Private Patient Protocols”. The protocols (which are still in force) require that:

- services for private patients must not interfere with service provision for publicly-funded patients and must not compromise the drive to reduce waiting times for elective surgery
- patients must be aware of publicly-funded options before choosing to pay for treatment in public facilities and have the opportunity of independent vetting of any referral by an HHS specialist to themselves in a private capacity, or the HHS privately
- Shareholding Ministers’ approval must be obtained before HHSs embark on new lines of business involving private services.

12. The protocols proposed in this paper have a wider application than these existing arrangements, and will replace them.

PROTOCOLS FOR THE NEW ENVIRONMENT

13. DHBs will be responsible for arranging the provision of services which ensure the best health and independence outcomes for their populations, within available funding. The New Zealand Public Health and Disability (NZPHD) Bill sets out the objectives and functions of DHBs and also includes specific provisions which will help shape the relationship between DHBs and Maori non-government organisations:

- the requirement for the Act to be interpreted in a manner consistent with the Treaty of Waitangi means that DHBs will need to consider the principles of partnership, participation and protection when deciding which providers should be used for services for Maori; and
- the requirement for DHBs to continue to build Maori capacity for participating in the health and disability sector and for providing for Maori needs.

14. There are obvious benefits from using non-government providers for a wide range of publicly-funded services, and from co-operation between DHBs in their provider role and non-government providers, for example:
- non-Government GP organisations or Maori or Pacific providers working co-operatively with public hospitals to reduce preventable hospital admissions
 - a DHB contracting with a private hospital to take patients at peak times, or to reduce backlogs for elective surgery, if funds are available
 - a private provider being allowed to provide a service for private patients from a DHB facility in order to retain a specialist in the local area and make a public service viable.
15. However there are also significant risks in designing the interface between the government and non-government health sectors. These risks are discussed under the following two sections which consider publicly-funded and privately-funded services in turn.

PUBLICLY-FUNDED SERVICES

16. When DHBs choose providers for publicly-funded services there are three key risks:
- *over-reliance on DHB providers:* It is likely that some DHBs will be inclined to use their own providers in preference to other options that would be more effective for achieving gains in health or independence. Some DHBs may also wish to expand their range of publicly-provided and publicly-funded services when existing community, Maori or Pacific providers are better placed to service target groups.
 - *inappropriate use of non-government providers or facilities for financial gain by DHB contractors, staff, board or committee members:* Many people involved in DHB decision-making will also work in the non-government health sector and may stand to benefit financially from a decision to use that sector for publicly-funded services. In this situation, financial incentives could result in decisions being made that are not in the best interests of public services and patients. The NZPHD Bill includes strong measures to address this risk in respect of Board members and committees. However potential conflicts of interest may also arise for DHB employees or contractors who are involved in making service arrangements for the DHB.
 - *adverse impact on DHB providers:* If DHB facilities are suitable for the effective and efficient provision of particular services, then we would expect DHBs to use them in preference to other facilities. However, there will be a number of circumstances where a non-government provider offers advantages in terms of health gain (eg a Maori provider may be the most effective option for delivering services to Maori). If services are moved to non-government providers or facilities to achieve health gains, this may have an adverse impact on the on-going viability and efficiency of DHB facilities.

Another risk in using non-government providers is that of DHBs having to meet unanticipated costs. For example, a private hospital, having been paid to treat public patients, may have to refer complicated cases back into a DHB facility. This will have an adverse impact on the DHB unless the possibility of referrals has been taken into account in the contractual arrangement.

17. A set of Provider Selection Protocols to address these risks is set out in Annex 1. The paramount consideration is that a provider for publicly-funded services should be the most effective option to achieve gains in health and independence for New Zealanders and close gaps within available funding. Other guidelines are proposed including one to ensure that DHBs observe Treaty principles and continue to build the capacity of Maori providers and another to guard against poor decisions arising from conflicts of interest. Annex 1A includes examples which show how the protocols will work.

PRIVATELY FUNDED SERVICES

18. Where a DHB's provider arm becomes involved in delivering privately-funded services the main risks are:
 - *Displacement of public patients:* Where the Government owns service providers (ie public hospitals and public health services), the presumption is that these providers and their facilities are exclusively for delivering publicly-funded services. If privately-funded patients are using these facilities, there is a risk that publicly-funded patients are getting less service than they should.
 - *Inappropriate use of public providers or facilities for financial gain by DHB contractors, staff, board or committee members:* As for publicly-funded care discussed above, people involved in DHB decision-making may stand to benefit financially from a decision to use public facilities for privately-funded services. In these situations, financial incentives could result in decisions being made that are not in the best interests of public services and public patients.
 - *DHB diverted from focus on public services:* If public providers or facilities are used for privately-funded services, there is a risk that management and clinical effort will be diverted away from the core business of providing services to public patients. This could happen, for example, if management spent much of its time seeking profitable private ventures, or recruiting new staff to offer a private component to a public service or new private services, instead of working toward better public services such as better integration of primary and secondary care, or better access to services by Maori and Pacific people.
19. A set of Private Involvement Protocols to address these risks is set out in Annex 2. The key criterion is that there must be a direct benefit to public patients or people with disabilities before a public provider or facility can be used for privately-funded services. This means that private involvement would need to

lead to an improvement in the clinical quality or the efficiency of a service for public patients. There must also be residual capacity after first serving public patients and an adequate level of publicly-funded service. Other guidelines are proposed to ensure transparency, avoid conflicts of interest, and limit the range of services that can be offered privately by a DHB provider. Examples illustrating how the protocols will work are set out in Annex 2A.

TRANSITIONAL MEASURES

20. This paper has been prepared looking forward to the DHB environment. However, many of the examples listed in Annexes 1A and 2A have arisen as proposals from HHSs which need to be addressed now. I propose that the protocols apply to the Health Funding Authority and the HHSs as soon as possible. This will prevent any new arrangements being entered into and then rolled-over to the DHBs that do not comply with the protocols.

IMPLICATIONS FOR CLOSING THE GAPS

21. The main risk is that some DHBs may choose to use DHB hospital-based services when a community provider, or a Maori or Pacific provider would achieve greater health gains for Maori or Pacific people. This risk will be addressed through:

- making the achievement of gains in health and independence and closing gaps the paramount consideration
- the requirement that the NZPHD Bill be interpreted in a manner consistent with the principles of the Treaty of Waitangi and for DHBs to continue to build the capacity of Maori to provide for their own needs
- the requirement to continue to build Pacific capacity for participating in the health and disability sector and providing for Pacific peoples' needs.

22. However the main mechanism for assessment of DHB proposals for closing gaps will be the review of their strategic and annual plans and approval by Ministers.

FINANCIAL IMPLICATIONS

23. The protocols will impact on DHBs' opportunities to contract with providers in the non-Government sector and, in particular, limit the opportunity to earn extra revenue from private patients. However private activity has been limited to date and the protocols will still allow for some private activity, therefore no change to Vote: Health is sought.

LEGISLATIVE IMPLICATIONS

24. There are no legislative implications.

HUMAN RIGHTS

25. There are no human rights implications.

REGULATORY IMPACT STATEMENT

26. This paper does not require a Regulatory Impact Statement as it does not propose any Bill or statutory regulation.

PUBLICITY

27. HHSs and the HFA will be advised of the protocols and this paper will be placed on my website.

CONSULTATION

28. The following departments have been consulted in the preparation of this report: Department of Prime Minister and Cabinet, Treasury, Te Puni Kokiri, Pacific Island Affairs, State Services Commission, Health Funding Authority.

AT THE MEETING ON 2 OCTOBER 2000, FOLLOWING REFERENCE FROM THE CABINET SOCIAL POLICY AND HEALTH COMMITTEE, CABINET:

CAB (00) M 32/2A(2)

DISTRICT HEALTH BOARDS AND THE NON-GOVERNMENT HEALTH SECTOR

This minute amends and replaces SPH (00) M 25/7

- a. **agreed** to the Provider Selection Protocols set out in Annex 1 (attached), to guide District Health Boards (DHBs) in making arrangements for the funding and delivery of publicly-funded health and disability support services;
- b. **agreed** to the Private Involvement Protocols set out in Annex 2 (attached), to guide DHBs' involvement in the delivery of privately-funded health and disability support services;
- c. **agreed** that, in the period up until DHBs are established, the protocols set out in the Annexes referred to above will apply to the Health Funding Authority and to Hospital and Health Services in respect of any new service arrangements.

ANNEX 1 Provider Selection Protocols

The choice of providers/facilities for publicly-funded services should:

- a) first and foremost, be the most effective option to achieve gains in health and independence for New Zealanders and close gaps within available funding
- b) in respect of services for Maori, continue to build Maori capacity for providing for Maori needs and, in respect of services for Pacific people, continue to build Pacific capacity for providing for Pacific peoples' needs
- c) In respect of hospital-based services, publicly provided services are preferred, all other things being equal
- d) be consistent with any specific requirements set out in other Government policies (eg those for primary care organisations which are currently under discussion)
- e) where a DHB has a significant proposal to out-source services, or to start providing services previously provided by a non-government provider, this should be included in the strategic and annual plans for approval by Ministers
- f) where a service is shifting from a DHB provider or facility¹, the shift should result in benefits to patients that outweigh any costs (in terms of deterioration in financial performance or reduced viability of existing DHB services or facilities)
- g) be listed in the DHB's annual report²
- h) be required to provide the same set of information to the DHB (eg on numbers of patients seen, details of services provided etc) regardless of whether the provider is publicly-owned or not
- i) where a DHB employee or contractor has a financial interest in a non-government provider (eg as an owner, director, or employee) and has influence over a decision to enter a service agreement with that provider:
 - ⇒ the Board must be advised of the potential conflict
 - ⇒ the Board (rather than a committee or individual/group acting under delegation from the Board) must explicitly approve the arrangement, together with any measures that may be required to manage the conflict
 - ⇒ if the arrangement is approved by the Board, details must be disclosed in the DHB's annual report.

¹ Including a service run by a number of DHBs together.

² Where large numbers are involved, such as in the case of GPs or pharmacies, providers could be described in a generic way rather than listing each one.

ANNEX 1A Examples of Application of Provider Selection Protocols

The following examples illustrate how the proposed Provider Selection Protocols for publicly-funded services, set out in Annex 1, would work.

Public provider		Other provider	
<i>Public facility</i>	<i>Other facility or equipment</i>	<i>Public facility</i>	<i>Other facility</i>
<p>Proposal for DHB to set up & run its own rest home (mix of public & private funding) ⇒ <i>would need to be submitted for approval by Minister & justified as more effective than using an existing private provider or developing one outside the DHB</i></p> <p>DHB plan to run a Maori health promotion programme itself ⇒ <i>DHBs are required to build capacity of Maori to provide for their own needs</i> ⇒ <i>proposal would need to be demonstrated to be more effective than using a Maori provider</i></p>	<p>Proposal for Hamilton Radiology to install a privately-owned CT scanner at Thames Hospital to be operated by Thames Hospital staff for use by public & private patients ⇒ <i>likely to be OK as Thames residents currently have to travel to a larger centre to have a publicly-funded CT scan</i></p> <p>⇒ <i>need to follow process set out in the protocols if there is potential for a conflict of interest</i></p>	<p>Proposal for a Timaru ophthalmologist to locate a clinic at Timaru Hospital to service private and public patients ⇒ <i>public use likely to be OK if this is the best option for securing ophthalmology services in the area</i> ⇒ <i>need to follow process in protocols if there is potential for a conflict of interest</i></p> <p>Proposal for secondary care budget holding by a primary care organisation ⇒ <i>not OK as not consistent with specific requirements of the primary care strategy (currently under discussion - not yet finalised as policy)</i></p>	<p>DHB funds CCS to provide support services to people with disabilities ⇒ <i>likely to be OK if it is the most effective option for achieving gains in independence within available funding</i> ⇒ <i>need to follow process in protocols if there is any potential for a conflict of interest.</i></p> <p>DHB funds a Maori provider of a well-child service: ⇒ <i>OK if best option for closing gaps and building capacity of Maori to provide for their own health needs</i></p>

ANNEX 2 Private Involvement Protocols³

Proposals for involvement in privately-funded service provision will need to be included in the DHB's strategic and annual plans for approval by Ministers. Use of a public provider or public facility for privately-funded services is only likely to be acceptable if all of the following conditions are met:

- a) first and foremost, there is a direct benefit to publicly-funded patients or people with disabilities, ie the private involvement leads to an improvement in the clinical quality or the efficiency of a service for public patients
- b) there must be spare capacity beyond that required for services to public patients, that is:
 - ⇒ the level of publicly-funded service already meets or exceeds any service guidelines set out in the Funding Agreement with the Minister
 - ⇒ the private involvement must not interfere with service provision for publicly-funded patients and must not compromise the drive to reduce waiting times for elective surgery
- c) patients must be advised of publicly-funded options before choosing to pay for treatment in public facilities, and be offered the opportunity of independent vetting of any referral by a DHB specialist³ to themselves in a private capacity
- d) if DHB staff will be directly involved in the delivery of privately-funded services (as opposed to the DHB simply making spare facilities or land available), the services must be part of the range and standard of services (clinical and non-clinical) that are publicly-funded
- e) there is public disclosure of the arrangement in the DHB's annual report
- f) where a DHB employee or contractor has influence over a decision for a DHB to be involved in privately-funded care, and has a financial interest in the arrangement (including through the potential for patients to be referred to the privately-funded service from a DHB-funded service):
 - ⇒ the Board must be advised of the potential conflict
 - ⇒ the Board (rather than a committee or individual/group acting under delegation from the Board) must explicitly approve the arrangement, together with any measures that may be required to manage the conflict
 - ⇒ if the arrangement is approved by the Board, details must be disclosed in the DHB's annual report.

³ These protocols do not apply to:

- services funded by the ACC and other accident insurers
- the treatment of ineligible patients from overseas who require urgent care but have not come to New Zealand seeking that care.

ANNEX 2A Examples of Application of Private Involvement Protocols

The following examples illustrate how the proposed Private Involvement Protocols for privately-funded services, set out in Annex 2, would work.

Public provider		Other provider*
Public facility	Other facility or equipment	Public facility
<p>Cornwall Suite at National Women's offering non-clinical "extras" to maternity patients for a charge ⇒ <i>not OK as not part of the range and standard of services offered publicly</i></p> <p>Proposal from Healthcare Hawkes Bay to offer orthodontic services to young people from low income families and charge at cost ⇒ <i>not OK as these services are not part of the range of services that are publicly-funded (but could submit a case if the services were considered necessary to achieve health gains and close gaps)</i></p> <p>A+ offering renal dialysis services to ineligible foreign patients for a charge ⇒ <i>not OK as no direct benefit to public patients</i></p>	<p>Health Waikato proposal for Hamilton Radiology to install a privately-owned CT scanner in Thames Hospital to be operated by Thames Hospital staff for both public & private patients ⇒ <i>private use of the scanner is likely to be OK as it makes the service for public patients viable</i></p> <p>⇒ <i>need to be satisfied that the DHB is meeting service guidelines for public patients</i></p> <p>⇒ <i>need to follow the process set out in the protocols if there is potential for a conflict of interest.</i></p>	<p>Proposal for a private geriatric hospital/rest home to operate from unused space in a rural public hospital (mix of public & private funding) ⇒ <i>would need to show the direct benefit to public patients which might come from enhanced viability of a rural hospital campus</i></p> <p>⇒ <i>involves only the use of a spare DHB facility</i></p> <p>⇒ <i>need to follow the process set out in the protocols if there is potential for a conflict of interest.</i></p> <p>Health Waikato proposal to make an under-utilised catheterisation facility available to Southern Cross for a set fee for use by private patients ⇒ <i>not OK as no direct benefit to public patients</i></p> <p>Proposal for a new private hospital to be located on Northland Health campus ⇒ <i>would need to show a direct benefit to public patients</i></p> <p>⇒ <i>involves only the use of a spare DHB land</i></p> <p>⇒ <i>need to follow the process set out in the protocols if there is potential for a conflict of interest.</i></p>

* The fourth combination - other provider/other facility - is of no direct interest to Government in this context.