

**OFFICE OF THE
MINISTER OF HEALTH**

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

**THE ROLE OF DISTRICT HEALTH BOARDS AND THE DIVISION OF FUNCTIONS BETWEEN
DISTRICT HEALTH BOARDS AND THE MINISTRY OF HEALTH**

PROPOSAL

1. I propose that:
 - DHBs will be responsible for deciding on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, NZ Disability Strategy and nationwide minimum service coverage and minimum quality standards (such as the Health and Disability Code of Rights)
 - DHBs will evolve towards maximum autonomy as they become capable.

EXECUTIVE SUMMARY

2. This paper clarifies the roles of DHBs and the Minister and Ministry of Health, in particular how much autonomy fully capable DHBs would be expected to have when they perform well.
3. DHBs will be accountable to the Minister, but elected members will also be answerable to their local community. This contributes to Government's objective that local communities have greater say over health and disability services, but is also likely to reduce the degree to which the Minister has control over DHBs.
4. I propose that, to achieve Government's objectives of improving health and independence of the population and increasing community say over health and disability services, DHBs should have responsibility for making decisions on the mix, level, and quality of health and disability services. DHBs would work within the parameters of the New Zealand Health Strategy, NZ Disability Strategy, and a nationwide minimum service coverage and minimum quality standards. This degree of autonomy of DHBs has implications for the organisational form, governance and accountability arrangements.
5. The recommended degree of autonomy also has implications for the role of the Minister of Health. That is, Ministers would generally not intervene in the operations and decisions of DHBs, focusing instead on setting the broader direction and outcomes sought (for example, through the New Zealand Health Strategy and the Disability Strategy), and use reserve powers to intervene sparingly. If, instead, the Minister of Health is to have greater influence on the day-to-day decisions of DHBs, then the sector would be more centralised and DHBs would have correspondingly less responsibility for the health and independence of their populations.
6. Regardless of the envisaged degree of DHB autonomy, a key issue is whether DHBs evolve to that state of autonomy, or whether all DHBs will start with the maximum level of autonomy anticipated. I propose that the sector will evolve from an initially fairly regulated and prescribed environment to a state where DHBs have the maximum degree of autonomy envisaged. Officials will design a framework that sets out how fast, how far and under what circumstances DHBs get to the envisaged degree of autonomy. This framework would be part of the operating environment, and not defined in legislation.

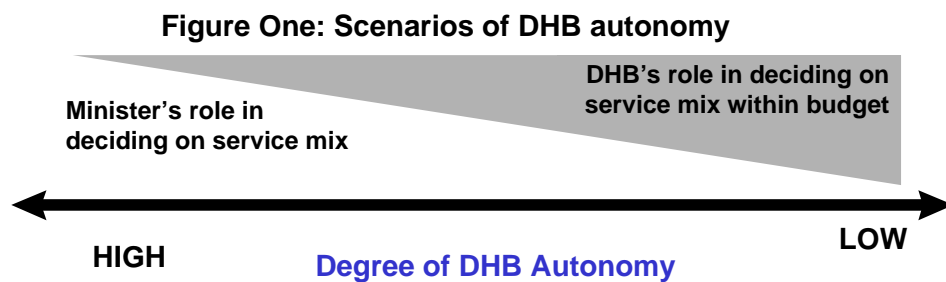
7. Decisions flowing from this paper will inform the work on the more detailed division of roles between DHBs and the Ministry of Health recommended for report back by the end of April 2000.

BACKGROUND

8. This paper provides further advice on the role of District Health Boards (DHBs) and the division of functions between DHBs and the Ministry of Health [CAB (00) M 2/4 refers].
9. Cabinet has already decided on the objectives and functions of DHBs [CAB (00) M 2/4 refers]. The key issue, however, is how much decision-making authority DHBs should have, and what decisions are to be made by the Minister of Health.
10. Decision-making authority for each of the following tasks could be placed with the Minister, devolved to DHBs, or shared:
 - setting strategic directions and objectives for DHBs
 - deciding the level, mix and quality of services
 - deciding which providers to use
 - monitoring service performance and health outcomes
 - managing hospital and related services' assets.
11. Decisions will have implications for organisational form and governance of DHBs, and accountability arrangements (content and process) for DHBs. They will also determine what roles the Ministry of Health would have in addition to its current policy advice, performance management, safety and regulation, and ministerial servicing functions.

DEGREE OF DHB AUTONOMY IN MAKING DECISIONS ON SERVICES

12. Cabinet has already decided that DHBs will be accountable to the Minister of Health for carrying out their functions within allocated funding. Through their elected members, however, District Health Boards will feel answerable to their local community. This gives the community greater involvement in decision-making about health and disability services, but it also transfers some decision-making power to DHBs away from the centre.
13. Within decisions made by Cabinet to date, there are many models for the decision-making role of DHBs between the extremes of a very centralised and a fully autonomous health and disability sector (see *Figure One*). At any point in time, the relationship between the Minister and DHBs on each of the dimensions or tasks may vary. My intention is to define the maximum level of autonomy desired for DHBs which perform well.



Scenario 1. Low DHB autonomy (local implementation of central decisions)

14. In this scenario, DHBs' prime role would be to consult with the community, and then provide input into the New Zealand Health Strategy and funding decisions. The Minister sets out the detailed mix, level and standard of services DHBs will fund or provide. DHBs implement these detailed decisions. The more capable DHBs would have a role in deciding *how* to do this: that is, whether to 'make or buy' services. There would be a strong emphasis on national service frameworks, protocols and guidelines. Overall, the Minister of Health would have a significant role in what DHBs do from day-to-day (see *Table One* below).
15. The role of the Minister of Health, assisted by the Ministry and in consultation with the DHBs, would be to:
 - define strategic directions (for example, the NZ Health Strategy with health goals and targets and sector performance standards, and the Disability Strategy)
 - define the detailed mix, level and quality of services DHBs will fund or provide
 - define the operating environment (the administrative rules for DHBs, such as user-charges regime, rules around raising private finance, and any limits on entering into arrangements with private providers)
 - define national service frameworks, protocols and guidelines
 - enter into funding agreements with DHBs
 - exercise reserve powers (such as the ability to direct DHBs, or appoint a commissioner in case of repeated performance failures).

DHBs are likely to be small organisations, in comparison to the scenario that follows, but with a larger Ministry of Health.

Scenario 2. High DHB autonomy (local decision-making within central parameters)

16. In this scenario, DHBs would have as much responsibility for making decisions on the mix, level, and quality of services as they are capable of carrying out effectively and efficiently. DHBs would decide – based on local needs analysis and strategic planning and in consultation with the Minister and the community – on the mix and level of services and the quality of those services to achieve the NZ Health Strategy and local priorities. The Minister would fund DHBs to deliver on agreed service intentions and performance measures including minimum quality standards, such as the Health and Disability Code of Rights and existing minimum quality standards, but DHBs would have considerable flexibility about the use of funds. Accountability documentation would eventually tend to focus on outcomes, but is likely to contain agreed output and process targets/goals (See *Table One* below).
17. Under this scenario, decision-making power is placed as close to the community as is effective and efficient, and the Minister (or Ministry) of Health only carries out functions on behalf of, or instead of, DHBs if the centre can do things better than DHBs could. For example, the Ministry could facilitate DHBs with standardisation of processes and there may be some health and disability services that are better co-ordinated or funded from the centre or regionally, such as some tertiary services, specialised mental health services, services provided by single national providers, and some public health services.
18. The role of the Minister of Health, assisted by the Ministry and in consultation with the DHBs, would be to:

- define strategic directions (for example, the NZ Health Strategy with health goals and sector performance standards, and the NZ Disability Strategy)
- define a nationwide minimum service coverage and minimum quality standards (the scope and detail of this service coverage will influence the degree of DHB freedom)
- define the operating environment (the administrative rules for DHBs, such as the extent of user-charges, rules around raising private finance, and any limits on entering into arrangements with private providers)
- enter into funding agreements with DHBs
- exercise reserve powers (such as the ability to direct DHBs, or appoint a commissioner in case of poor performance).

DHBs are likely to be larger organisations, in comparison to the first scenario, but with a smaller Ministry of Health.

Advantages and disadvantages in options on the degree of DHB autonomy

19. A single set of criteria has been applied in assessing the advantages and disadvantages of the options. The criteria are:
 - clarity of accountability to the Crown and to the community
 - transparency of decision-making
 - consistency with the Treaty /relationship with Māori
 - efficiency (including transactions and administration costs)
 - equity of access (including nationwide consistency)
 - management of fiscal risk to the Crown
 - public confidence.
20. The comparison of the main advantages and disadvantages of the options shows that, as decision-making authority is shifted along the spectrum from the centre to the DHBs, it:
 - decreases the Minister's role in detailed decisions if DHBs perform well, and increasingly emphasises the Minister's role as strategic direction setter
 - decreases the leverage of the Minister of Health, but increases the role and responsibility of the Board and the ability of the community to be involved in decisions about local services
 - increases DHB staff and infrastructure (and reduces the size of the Ministry of Health) and the need for co-ordination across districts which may increase the costs over a system where activities are carried out centrally, but also increases the likelihood that services are tailored to local needs and preferences and are better co-ordinated within districts
 - decreases the likelihood that there is nationwide consistency in who gets what for all health and disability services, but increases the likelihood that the service mix reflects local values and is targeted at local needs
 - reduces central control over detailed fiscal management but increases local awareness of, and responsibility for, making trade-offs within a budget.

21. In each case, governance and accountability tools can be used to mitigate the identified risks:

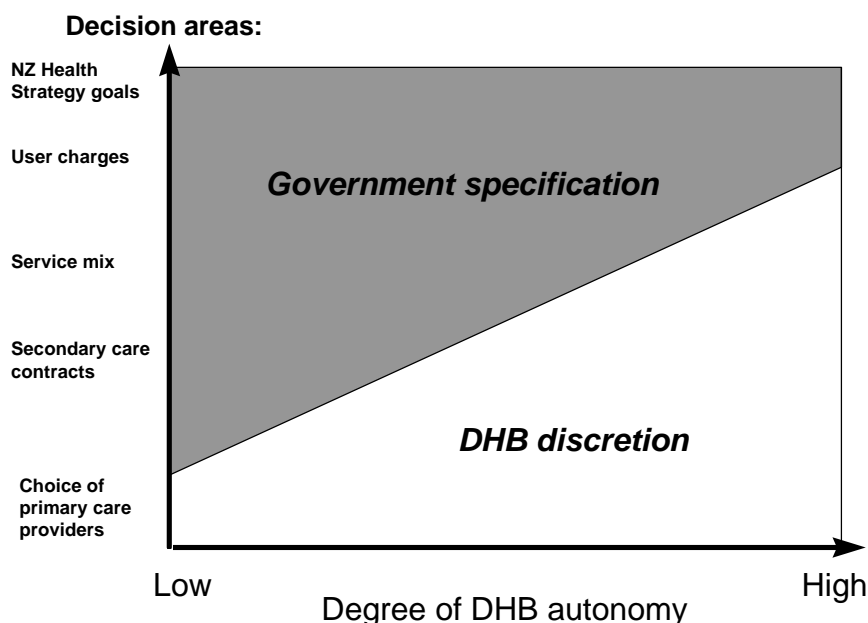
- the risk that there is unchecked variation in the health and disability services which people could expect by DHB can be mitigated by continued development and publication of a nationwide minimum service coverage and minimum quality standards, in consultation with all DHBs, and so identifying where DHBs can or cannot vary the range and level of services they fund or provide
- the risk of increased administrative and transactions costs can be mitigated by setting up common services agencies (for example, information technology or property maintenance), or having the Ministry carry out some analytical and contracting tasks on behalf or instead of DHBs.

22. Under both scenarios, the Minister is likely to face tensions with the local representatives on the Boards of DHBs. The governance report back covers some means to mitigate that political risk.

Table 1	Low DHB autonomy	High DHB autonomy
Strategy	<ul style="list-style-type: none"> • The Minister sets the strategic direction and very detailed priorities for the sector • DHBs consult with community and provide input to the NZ Health Strategy • DHB strategic planning is focused on implementation of detailed national priorities • The Ministry develops national service strategies, frameworks, protocols and guidelines for implementation by DHBs 	<ul style="list-style-type: none"> • Minister decides on NZ Health Strategy contents, following close consultation with DHBs • DHBs consult community on local priorities • DHB strategic planning is focused on meeting high-level NZHS outcomes and balancing national and local priorities • Ministry leads joint development of national service strategies
Mix, level, and quality of services	<ul style="list-style-type: none"> • The Minister decides on the detailed mix, level, and standard of services • DHB funds are tied to specific outputs • Capable DHBs may decide on whether to buy services or provide these themselves • Ministry administers regulation, national quality standards and protocols 	<ul style="list-style-type: none"> • Minister decides on a minimum service coverage and quality standards (in consultation with DHBs) • DHBs draft a service plan (mix, level, and standard of services) based on NZHS, service coverage and local priorities for Minister to approve • Minister funds DHBs to deliver on agreed service intentions and performance expectations • Ministry administers regulation • DHBs set local quality guidelines and service protocols
Choose providers	<ul style="list-style-type: none"> • Ministry runs a significant central purchasing role • for a range of services, capable DHBs have discretion in deciding which local providers to fund 	<ul style="list-style-type: none"> • DHBs enter into arrangements with providers • for some services, such as selected national services, the Ministry chooses and funds providers directly (when this is more efficient) • DHBs contribute to national and regional service decisions
Outcome and Service monitoring	<ul style="list-style-type: none"> • The Ministry monitors the performance of DHBs, including DHB provided services • The Ministry monitors providers it has a service agreement with • DHBs monitor providers' delivery on service agreements • Ministry monitors progress against national targets • DHBs monitor local progress and reports to Ministry 	<ul style="list-style-type: none"> • The Ministry monitors the performance of DHBs • Ministry has minimum service agreements to monitor • DHBs monitor providers against service agreements, including own provision arms • Ministry has an oversight (audit) role of DHB provided services • Ministry monitors progress against national targets • DHBs monitor local progress and reports to Ministry

23. I recommend that DHBs should have responsibility for making decisions on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, Disability Strategy and nationwide minimum service coverage requirements. This means that, once DHBs are fully established, the Minister of Health would focus on the strategic direction and the health outcomes that the DHBs are to achieve, rather than the decisions over how to achieve those (see *Figure Two*).

Figure Two: Roles of Minister & DHBs



Detailed division of roles between DHBs and Ministry of Health

24. I propose that once Cabinet has made decisions about the desired degree of autonomy for DHBs, officials will complete the next phase of working through who will define services in more specific service areas, such as tertiary services, services delivered by nationwide providers, mental health, disability support and public health services. The exact division, however, of service funding roles between DHBs (individually or jointly) and the Ministry of Health is likely to emerge over time as DHBs become established.
25. I recommend that Cabinet direct officials to report back by the end of April 2000 with in-principle advice on a more detailed service-by-service division of responsibilities. This timetable will allow work to proceed on the report back on funding arrangements due on 30 June.

THE ROLE OF DHBs IN OWNING CROWN HEALTH ASSETS

26. There is always a tension between the Crown's interest as a *funder* of services and that as the *owner* of provider organisations. Managing within a defined budget means that spending more on services means less is available to spend on or invest in assets (and vice-versa).
27. Cabinet decided that "The current Hospital and Health Services, their assets, liabilities and services will be part of the District Health Boards" [CAB (00) M2/4 refers]. Concerns are that:

- DHBs may be biased toward hospital-based services when they make decisions about the mix of primary care and community-based services and hospital-based services
 - DHBs may overinvest or inappropriately run down their assets. These concerns may materialise when a District Health Board does not face the full cost of using its own hospital facilities (for example, if there were no capital charge or it could defer maintenance).
28. Within the limits of Government's policy direction, there are a number of mechanisms which could be used to ensure transparency in how any tension between funding and ownership interests is managed. These are:
- a) accountability mechanisms that provide distinct reporting lines for funding and ownership responsibilities
 - b) establishment of separate committees of the Board responsible for primary care and hospital governance (as agreed by Cabinet)
 - c) structural arrangements that separate funding responsibilities and ownership responsibilities.
29. Mechanisms under (a) will be covered in the report-back on accountability arrangements, (b) will be the subject of a further report-back as recommended in the accompanying Governance paper, and (c) will be determined and approved as part of the DHB establishment process (see paragraph 32).
30. The degree of freedom a DHB may have in making decisions on their assets (for example, the extent to which they can borrow or sell assets) may not necessarily be the same as the degree of freedom a DHB would have on funding decisions.

EVOLUTION OF DHB AUTONOMY

District Health Boards are part of a complex, dynamic and evolving system

31. The design of the sector must take into account the dynamic nature of the health and disability sector where factors, such as evolving social preferences epidemiological trends and technological innovation, are likely to increase the demand for, and increase the efficiency and effectiveness of, local control.

DHB transition to the envisaged state of devolution

32. A distinction can be made between the degree of devolution to DHBs during the initial establishment and developmental stage and the prudent degree of devolution in relation to the performance of established DHBs. Given the evolutionary nature of the sector and the likely differences between DHBs, it may be difficult to distinguish between developmental and established DHBs. An important first step will be to define a formal process for establishment of DHBs which addresses issues such as internal structural arrangements (see paragraph 29) and the initial level of DHB autonomy. I propose that Cabinet directs officials to report back on this process.
33. Regardless of the degree of devolution that is envisaged for DHBs, there is a key issue whether DHBs evolve to a state of autonomy, or whether all DHBs will start from the envisaged degree of autonomy. The main arguments for starting from a point where DHBs have maximum autonomy are that it:

- gives DHBs control over, and thus clear responsibility for, their performance
 - shows trust in DHBs and their staff
 - avoids the possibility that responsibility may not be devolved at all (which would lead to disillusion in DHBs and reduced community involvement).
34. I propose an evolutionary approach where the DHBs' environment is initially fairly regulated and prescribed and is then progressively relaxed to a state where DHBs have the desired degree of autonomy. Advantages are that it:
- helps manage the substantial health outcome risks of under-performance by inexperienced Boards
 - avoids the potential that some DHBs have expectations placed on them which they will fail to meet (which would be demotivating)
 - allows for the inevitable variation among DHBs in developing their capability to carry out the full range of roles.
35. It is important that DHBs and the Minister share expectations about what is required to be successful, fully capable DHBs. The Ministry of Health, in consultation with officials, will develop and publish a detailed DHB development framework by November 2000, which sets out criteria and the process for moving toward autonomy. This will clarify how fast, how far and under what circumstances DHBs can expect to reach the maximum level of autonomy anticipated. The timeline allows the framework to be in place when the Transitional DHBs begin operations. The report-back on accountability arrangements will include an outline of this framework.
36. In addition, it will be important that the DHBs are resourced to be able to develop their organisations to a state of maximum devolution, and that the Ministry of Health (with the HFA and CCMAU) will support DHBs in doing so.

Varying DHB decision-making authority in response to performance concerns

37. Another fundamental issue is to what extent the Minister can vary the degree of decision-making authority, once DHBs are fully operational. The Minister of Health may, from time to time, wish to negotiate more detailed expectations. That is, the Minister would reduce a DHB's autonomy by being more specific about what services a DHB is expected to deliver and/or what processes to use). This may be the case if a DHB does not have the capability or if down the track its performance drops below an acceptable standard.
38. The Minister can do this by introducing far greater detail in funding agreements which the Minister would, from time to time, enter into with DHBs, and by providing the Minister reserve powers, such as the ability to direct DHBs and other means of influencing the Board (as set out in the report-backs on governance and accountability arrangements).
39. The ability to vary the degree of DHB autonomy has the following advantages:
- it allows for differences in DHB roles and capability – some DHBs may develop a wider range of capabilities than others
 - it provides a reward to DHBs (in the form of increased autonomy) for good performance and a sanction (in the form of Ministerial intervention in DHB operations) where there are serious performance concerns.

40. The main disadvantages are that responsibility may not be devolved when DHBs have the capability (leading to disillusion in DHBs and reduced community involvement), and that it may give rise to missed opportunities for increasing responsiveness of services.
41. The performance management framework which form part of the DHB accountability arrangements being designed will seek to mitigate such risks.

THE CROWN'S RELATIONSHIP WITH MÄORI

42. Mäori expect that, in addition to requirements to consult, sector arrangements continue to increase Mäori participation in health and disability services. This expectation reflects Government's commitment to self-determination for whānau, hapu and iwi and to fulfilling its obligations as a Treaty partner. Among the key objectives are to:
 - ensure a flexible environment that reflects the diversity of Mäori
 - ensure Mäori participation at all levels of the sector
 - improve the performance of mainstream health organisations in relation to Mäori health gain and Mäori preferences
 - improve Mäori consumer confidence in (and therefore use of) health and disability services in the sector.
43. Increasing the degree of DHB autonomy increases the likelihood that health and disability services are responsive diverse Mäori needs and that there can be local approaches and solutions. But it also puts greater distance between the Crown and Mäori, which may be interpreted as weakening the Crown's Treaty of Waitangi obligations.
44. Risks associated with a greater degree of devolution will be addressed through governance and accountability arrangements. This includes ensuring equitable Mäori representation on the Board and its committees as well as building from the partnership arrangements already in place at the HFA Board and operational levels: these structures and agreements (memoranda of understanding and deeds of partnership with local Mäori leadership) can either be transferred to DHBs or form a model for new partnership arrangements.
45. Over time these arrangements have the potential to evolve into stronger governance and purchasing functions for Mäori in relation to Mäori health gain and services within the District Health Boards. The flexibility principle allows other solutions to emerge over time which may be more appropriate. None of these options should be precluded. The proposals in the accompanying paper on Mäori partnership issues are capable of being adopted regardless of the degree of devolution the Government envisages for DHBs.

CONSULTATION

46. The following agencies were consulted in preparation of this paper: the Health Funding Authority, Crown Company Monitoring Advisory Unit, Department of the Prime Minister and Cabinet, The Treasury, Te Puni Kokiri, and the State Services Commission.

FINANCIAL IMPLICATIONS

47. Full identification of one-off costs and ongoing fiscal impacts of the proposed structural changes will be reported by 31 March 2000 [Cab 00 M2/4 refers].
48. The net financial implications of proposals in this paper relate principally to the level of investment needed to equip DHBs with the required capability and ongoing transactions

(including monitoring and co-ordination) costs and administrative costs. These include costs and savings from:

- changes in the nature, quantity, and frequency of agreements between DHBs and providers, and between DHBs and the centre:
 - more collaboration and common service agencies may reduce transactions costs
 - coordination costs may be greater in a more devolved sector
 - 22 DHBs will increase overall monitoring costs (assuming the nature and scope of Crown health assets monitoring activity stays largely unchanged)
- changes in administrative costs in terms of the number of staff and infrastructure required by DHBs, and the size of the central administration (the sum of the Ministry of Health, HFA, CCMAU).

LEGISLATIVE IMPLICATIONS

49. The legislation required forms part of the New Zealand Public Health Services and Health Reforms (Transfer and Transitions Provisions) Bill.

COMPLIANCE COSTS STATEMENT

50. The proposals do not have compliance costs implications beyond those identified as part of financial implications above.

REGULATORY IMPACT STATEMENT

51. A Regulatory Impact Statement is attached.

HUMAN RIGHTS IMPLICATIONS

52. The proposals do not have Human Rights Act 1993 implications.

PUBLICITY

53. Publicity on matters related to this paper is managed as part of the Communications Strategy that forms part of the wider work on health and disability change.

CABINET:

- a agreed that the objective is that District Health Boards (DHBs) will have responsibility for making decisions on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, Disability Strategy and nationwide minimum service coverage and safety standards (such as the Health and Disability Code of Rights and existing minimum quality standards);
- b agreed that the DHBs' environment will initially be highly regulated and prescribed but will then be progressively relaxed as each DHB is progressed towards the maximum envisaged degree of autonomy;

- c agreed that the role of the Minister of Health, assisted by the Ministry of Health and in consultation with the DHBs, will be to:
- i define strategic directions for the health and disability sector;
 - ii define nationwide minimum service coverage and safety standards;
 - iii define the operating environment;
 - iv enter into funding agreements with DHBs containing the DHB-specific agreed performance targets;
 - v exercise reserve powers (such as the ability to direct DHBs or appoint a commissioner in case of repeated performance failures [SPH (00) M 6/4 refers]);

REPORT BACKS

- d noted that an outline of the DHB development framework is part of the 30 March 2000 report-back on DHB accountability arrangements to the Ad Hoc Ministerial Committee;
- e agreed that the Ministry of Health, in consultation with officials, report to the Minister of Health by November 2000 with a detailed DHB development framework, setting out the criteria and process by which individual DHBs will move to the maximum degree of autonomy;
- f directed the Health Sector Development Officials Group to report back to the Ad Hoc Ministerial Committee by 30 June 2000 on the process for establishing DHBs, addressing issues such as internal DHB structural arrangements and the initial level of DHB autonomy;
- g directed the Health Sector Development Officials Group to report back to the Ad Hoc Ministerial Committee by the end of April 2000 with in-principle advice on a more detailed service-by-service division of roles, to inform the 30 June 2000 report back on funding arrangements.

REGULATORY IMPACT STATEMENT

Objective

1. The policy objectives are:
 - to improve the health and independence of the population and reduce disparities
 - to improve health and disability service delivery
 - to increase community say over health and disability services
 - to encourage a collaborative health and disability sector
 - to reduce administrative costs.
2. The objective of this paper is to clarify the roles of DHBs and the Minister and Ministry of Health, and in particular how much autonomy fully capable DHBs would be expected to have when they perform well.

Statement of the problem and the need for action

3. Given the objectives and functions of DHBs, the issue is how much decision-making authority DHBs should have, which decisions are to be made by the Minister of Health and which decisions are shared.
4. Clarity on what degree of autonomy is envisaged for DHBs will assist in the more detailed division of roles between DHBs and the Ministry of Health.

Feasible options to achieve desired objectives

5. The paper sets out two main scenarios between the extremes of a very centralised and a fully autonomous health and disability sector. The key differences are in:
 - whether the Minister of Health or DHBs decide on the detailed mix, level, and quality of health and disability support services:
 - whether DHBs evolve to a state of autonomy, or whether all DHBs will start from the maximum degree of autonomy envisaged by Ministers.
6. The proposals are that:
 - DHBs will be responsible for deciding on the mix, level, and quality of health and disability services, within the parameters of the New Zealand Health Strategy, NZ Disability Strategy and nationwide minimum service coverage and quality standards (such as the Health and Disability Code of Rights and existing minimum quality standards)
 - DHBs will evolve towards the maximum desired degree of autonomy.

Non-regulatory measures

7. The proposal defines the Minister of Health's role and this must be included in the New Zealand Public Health Services Bill. No satisfactory non-regulatory mechanism exists which would achieve this.
8. The degree of autonomy for DHBs flows from the Minister of Health's role. Achievement of the maximum desired level of autonomy and the specification of a development path do not require regulatory measures.

Regulatory measures

9. A definition of the Minister of Health's role must be included in the New Zealand Public Health Services Bill to ensure clarity of roles and responsibilities in the publicly funded health and disability sector.

Statement of the net benefits of the proposals

10. The comparison of the main advantages and disadvantages of shifting decision-making authority along the spectrum from the centre to the DHBs, shows that it:
 - decreases the Minister's role in detailed decisions if DHBs perform well, and increasingly emphasises the Minister's role as strategic direction setter
 - decreases the leverage of the Minister of Health, but increases the role and responsibility of the Board and the ability of the community to be involved in decisions about local services
 - increases DHB staff and infrastructure (and reduces the size of the Ministry of Health) and the need for co-ordination across districts which may increase the costs over a system where activities are carried out centrally, but also increases the likelihood that services are tailored to local needs and preferences and are better co-ordinated within districts
 - decreases the likelihood that there is nationwide consistency in who gets what for all health and disability services, but increases the likelihood that the service mix reflects local values and is targeted at local needs

- reduces central control over detailed fiscal management but increases local awareness of, and responsibility for, making trade-offs within a budget.
11. On balance, the benefits of allowing DHBs to move as close to full autonomy as possible, subject to certain nationwide minimum requirements, are expected to be greater than the disadvantages.
 12. The benefits of DHBs evolving over time to the maximum state of autonomy envisaged are that it:
 - helps manage the substantial health outcome risks of under-performance by inexperienced Boards
 - avoids the potential that some DHBs have expectations placed on them which they will fail to meet (which would be demotivating)
 - allows for the inevitable variation among DHBs in developing their capability to carry out the full range of roles.
 13. The disadvantage is that it:
 - introduces a risk that responsibility may not be devolved at all (which would lead to disillusion in DHBs and reduced community involvement).
 14. On balance the advantages from an evolutionary approach outweigh the disadvantages.

Consultation

15. The following agencies were consulted in preparation of the Cabinet paper: the Health Funding Authority, Crown Company Monitoring Advisory Unit, Department of the Prime Minister and Cabinet, The Treasury, Te Puni Kokiri, and the State Services Commission.