

**OFFICE OF THE
MINISTER OF HEALTH**

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

GOVERNANCE OF DISTRICT HEALTH BOARDS

PROPOSAL

1. With this paper, I seek Cabinet Social Policy and Health Committee decisions on the most appropriate organisational form and governance arrangements for District Health Boards (DHBs) with the aim of ensuring sound governance.

EXECUTIVE SUMMARY

2. I propose that DHB Boards are to be unambiguously accountable to the Minister of Health for achieving health and disability outcomes for their populations. The governance arrangements for DHBs should then be based on this line of accountability. While recognising that the Board will have a combination of elected and appointed members this single accountability is necessary for the Board to be clear about its duties, and to be able to manage the tension inherent in the proposed structure.
3. I will also expect DHBs to establish close and strong links with communities and will hold them to account for doing so.
4. It is proposed that DHBs are established as Crown Entities (Statutory Corporations) with a flexible range of powers, tempered by accountability arrangements and other mechanisms which allow DHBs an appropriate degree of freedom to manage their affairs, while enabling the Minister of Health to exercise control where necessary and desired.
5. The role of the DHB Boards in providing strategic oversight of the organisations will be crucial in ensuring that the Government's objectives for the health and disability sector are achieved, and that fiscal risk is managed. Commensurate with the nature of the Board's task, the responsibilities and accountabilities of individual Board members are significant.
6. While DHB Boards would be held collectively accountable for the performance of the DHB, Board members would be held individually accountable for the care and skill they use in performing Board duties. An appropriate range of sanctions is necessary to address performance concerns and it is recommended that the most serious sanction (dismissal of an individual or the entire Board) is only able to be applied by the Minister of Health.

BACKGROUND

7. On 31 January 2000 Cabinet directed the Ministry of Health, in consultation with the Health Sector Development Officials Group, to report to the Ad Hoc Ministerial Committee on options for the organisational form of DHBs. This includes the role, accountability and reporting requirements of the Hospital Governance Committees and Primary Care Advisory Committees in order to minimise bias in DHB decisions toward hospital services (CAB (00) M2/4 gg (iv) refers).
8. This report has been considered by the Ad Hoc Ministerial Committee on Health Sector Change and has been approved for submission to the Cabinet Social Policy and Health Committee.

9. With regard to the governance of DHBs a number of parameters have been set by Cabinet. These are that DHBs will:
 - i. have a majority of elected board members, but will not be part of local government
 - ii. not be Crown companies, but be publicly owned
 - iii. fulfil purchase, ownership and regulatory roles
 - iv. be subject to Ministerial powers, which will include removal of boards and replacement with a commissioner
 - v. produce a health and disability sector in which greater emphasis is given to local community involvement
 - vi. will be able to merge with other DHBs on a voluntary basis.

GOVERNANCE AND THE DUAL NATURE OF RESPONSIBILITY OF THE BOARD

10. Governance, as executed by the DHB Board, is strategic oversight of the management of the entity to ensure it delivers on its fundamental objective of working within allocated resources to improve, promote and protect the health of a defined population, and to promote the independence of people with disabilities within a defined population.. The operational management of the DHB is undertaken by executive managers who are accountable to the Board.
11. The structure of the health and disability system proposed by Government deliberately blends different forms of governance through elected and appointed members, forms of control (central vs. local) and forms of accountability (to communities and central Government).
12. The Boards of DHBs, and elected members in particular, will be placed in a position where they feel a dual accountability - to both Ministers, and the community which elected them. Reconciling this tension, managing the necessary trade-offs and meeting expectations will be a constant challenge for the Boards of DHBs. This needs to be managed by creating a strong accountability to the Minister of Health.
13. A DHB Board needs to be in a position where often competing interests can be objectively considered. Central to the achievement of this objective is clarifying the role of elected members on DHB Boards, and the collective responsibility of the Board as a whole.
14. It will only be possible for the Board to achieve its overall objective of improved health and disability outcomes for the population if the Board is collectively responsible for decisions and accountabilities. It is, therefore, proposed that elected Board members, like the other Board members, are legally accountable to the Minister of Health for the responsibilities agreed by the Minister of Health for DHBs (which will include considering community priorities and Māori aspirations). Elected members will bring the community's perspective to Board deliberations and will provide a voice which emphasises the responsibility to the community.
15. This distinction makes both appointed and elected members equally responsible and accountable for executing the Board's responsibilities to central Government and the community, including managing within allocated resources. The detail of accountability mechanisms are to be determined by the Accountability Workstream due to report to the Ad Hoc Ministerial Committee by 31 March 2000.

Establishing and defining DHBs in statute

Establishment

16. Cabinet has agreed to introduce a New Zealand Public Health Services Bill into the House in May 2000. This Bill will disestablish the Health Funding Authority (HFA) and Hospitals and Health Services (HHSs) and establish DHBs.

17. To ensure flexibility, it is proposed that the individual DHBs are listed in a schedule to the Act by Order in Council. This process provides the ability to amend the schedule if DHBs are merged, dis-established, or divided in response to changes in policy settings, population catchments, or to save administration costs.
18. The move from HHSs to DHBs will be undertaken in two stages. Immediately following legislative change DHBs will be established with transitional boards pending the local body elections of 2001 when the combined board of elected and appointed members will be ready to be put in place. Issues related to transitional boards are discussed elsewhere in this document.

Organisational form

19. The most appropriate organisational form for DHBs is determined by the role of DHBs, the relationship between DHBs and the Crown, and between DHBs and local communities.
20. DHBs will be funded from general taxation, fulfil purchase, and delivery roles, and be subject to certain Ministerial powers. They will be part of a health and disability system in which greater emphasis will be given to local needs, through boards with a locally elected majority. DHBs will be accountable to the Minister of Health, will be expected to give effect to Government policy, and will generally be large and complex organisations.
21. Two of the three broad organisational forms in executive government are clearly inappropriate for DHBs, namely, Departments and State Owned Enterprises. The former because there would be no legal separation from the Crown. This close relationship with the Minister/Crown would not give DHBs autonomy in operational and day-to-day decision making. The latter is inappropriate because SOEs are companies and Cabinet has made clear that DHBs will not be companies.
22. The third category is Crown Entities, as defined by inclusion in the Fourth Schedule of the Public Finance Act. Crown Entities are legally separate from the Crown, but most have a substantial relationship with it. Crown Entities come in four basic legal forms; statutory corporation, corporation sole, trust and company.
23. Trusts, companies and corporations sole are not suitable organisational forms for DHBs given their role and the parameters determined by Cabinet as:
 - a) Cabinet has clearly decided that DHBs will not be companies.
 - b) Trusts are set up to make grants, or promote certain objectives. As trusts the Crown would cease to own the assets of DHBs, and the capacity for Ministerial direction would be minimal.
 - c) Corporations sole are small bodies which are headed by a single statutory officer. This arrangement is unsuitable for DHBs.
24. Therefore, a statutory corporation is deemed the most appropriate legal form for DHBs. The actual autonomy of DHBs under this structure and the distance of the DHB from the Minister of Health will be determined by the confirmed role of DHBs.
25. A statutory corporation would mean that DHBs have:
 - i. independence from the Minister of Health which facilitates involvement of the local community, and does not involve the Minister of Health in operational matters
 - ii. accountability under the Public Finance Act provides consistency in the financial and reporting requirements
 - iii. their own governing legislation and the accountability arrangements specified within that
 - iv. a relationship with the Minister of Health which allows the Minister of Health to exert influence over the DHB via accountability arrangements.

26. It is anticipated that, in the future, the work currently underway on Crown Entity governance will lead to legislative change to the classification and typology of Crown Entities which will further define the degree of separation between entities and the Crown. This work is in progress but does not currently consider complex hybrid forms of governance as proposed for DHBs. It is not possible for the organisational form for DHBs to be legislated to reflect the classifications being developed. Officials have been mindful, however, of the potential changes and are aware that the applicability of the new classification to DHBs will need to be considered when the legislation proposed by the State Services Commission is further developed. A consequential amendment to the legislation establishing DHBs may be required in due course.

Powers of DHBs as corporate bodies

27. DHBs require a range of powers in order to conduct their business, for example, the ability to:
- i. charge (e.g. for overseas patients not covered by a mutual agreement for the provision of services, and ACC)
 - ii. set up subsidiaries
 - iii. engage in a particular scope of business
 - iv. provide services for other DHBs via contract
 - v. participate in co-operative and collaborative arrangements with other DHBs.
28. These powers will be vested in the DHB Board who should also be able to:
- i. appoint and dismiss the Chief Executive; and
 - ii. delegate functions, duties and powers as appropriate.
29. It is proposed that DHBs powers are established in statute by giving the DHB all the rights, powers and privileges, and the ability to incur all the liabilities and obligations, of a natural person (of full age and capacity).
30. The risks posed by the exercise of these powers can be mitigated by:
- i. an express statement in the Act of the objectives of a DHB. The Act would also contain a provision for other objectives to be agreed between the Minister of Health and the DHB if circumstances require
 - ii. in particular circumstances, requiring the express permission of Ministers to exercise a power (e.g. the ability to raise loans without the consent of the Minister of Finance)
 - iii. requiring DHBs to act in the best interests of the Crown as owner
 - iv. clear accountability arrangements which reflect the detail of the Government's position
 - v. the ability to dismiss the Board or Board members in specified circumstances
 - vi. transparent processes, consultation and the involvement of the community in decision making.
31. It is preferable that all of the detail of risk mitigation is not prescribed in detail in legislation, but is negotiated through other mechanisms (to be reported on by the Accountability Workstream on 31 March 2000).

Governance by a Board

32. The Governance of individual DHBs will be the responsibility of a Board.

Role of the DHB Board

33. The role of the Board is to govern the DHB by directing, supervising, and monitoring the conduct of the entity's business. The Board is responsible for setting the strategic direction of the DHB, monitoring the performance of the entity, managing risk, providing good stewardship, and for overseeing the management of the significant Crown resources which are entrusted to it. The Board in turn appoints (and can dismiss) the Chief Executive to implement its policies, manage the resources of the organisation, and run its day-to-day operations within the parameters set by the Board.
34. It is not necessary, or desirable, for legislation to prescribe the detail which sits beneath this high level role. It will, however, be important for this detail to be clearly communicated through an appropriate channel to Board members. It is proposed that mechanisms such as the existing Crown Entity Guidelines and a letter of expectation of good governance from the Minister of Health, when a person becomes a member of a DHB Board, be used for this purpose. The accountability documents will further clarify the Minister of Health's expectations of the role of the Board, relationships, incentives and sanctions. This work is being undertaken by the Accountability Workstream.
35. The Chair would be responsible to the Minister of Health for the overall performance of the DHB in meeting expectations and delivering outcomes. The Chair is also expected to undertake performance monitoring of individual Board members and address issues in this regard as they arise.
36. The Board is also responsible for delegating responsibility for employment matters to the Chief Executive. It is not appropriate that the Board is involved in staffing issues beyond the appointment of the Chief Executive.

Prudent financial management

37. The DHBs and their governing Boards will be in control of significantly large sums of Crown provided revenue and, potentially, capital. This exposes the Crown, as owner and funder of DHBs, to some significant financial risks. The Crown as owner of the DHBs will be ultimately responsible for the consequences of all decisions of DHBs and their Boards that result in future financial or contractual commitments.
38. The Board will be both responsible and accountable for ensuring that the DHB operations are not carried out in a manner that is likely to create substantial risk to the Crown. For example, the Board must ensure that commitments and contracts entered into by the DHB can be met from within known or expected revenues and capital commitments from the Crown or any other source.
39. The Crown will want to protect its ownership interest by ensuring that sound financial management principles be included in legislation to support the governance of the DHBs. The DHBs, similar to other Crown entities, in fulfilling their purpose, will be expected to operate in a financially responsible manner so that they maintain their long term financial viability and operate as going concerns.
40. Further work relating to effective DHB financial management needs to be undertaken. This will need to cover issues such as appropriate capital structures for DHBs, sources of finance and the borrowing powers of DHBs, taxation status, and frameworks for the monitoring of investment decisions. These are important issues and will be considered in detail by the Officials Group.

Responsibilities of Board members

41. The overall responsibility and accountability of the Board is to the Minister of Health. In order for the Board to achieve its overall objective of improved health and disability outcomes for the population, and manage the tensions inherent in this objective, the Board members should be held collectively accountable. The detail of that accountability will be reported back by the Accountability Workstream.

42. The responsibility, and accountability, of individual Board members is to bring their knowledge, skills and expertise to bear on the Board's considerations. For elected members this includes bringing the perspectives of the community to the Board.
43. The responsibilities, duties and expectations of Board members in conducting Board business are that Board members will:
- i. act in the best interests of the DHB and Crown as owner (this is a complex issue which will be the subject of further work by Officials)
 - ii. disclose and manage conflicts of interests (see later section called 'Disclosure and conflict of interest')
 - iii. act with reasonable care and skill
 - iv. obtain additional help when there is insufficient skill or knowledge within the Board membership
 - v. obtain training and maintain the currency of their skills
 - vi. undertake peer review of their performance
 - vii. have regard of the Treaty partnership
 - viii. put in place systems to provide sufficient information to understand the performance of the organisation
 - ix. delegate appropriately to management and adequately monitor that delegation
 - x. put in place policies and systems to provide checks and balances on management
 - xi. provide strategic oversight and direction to DHBs
 - xii. provide sound financial management.
44. In addition, both kinds of members will have the following duties which provide a clear understanding of the expectations of Board member conduct.
- i. the duty to act in good faith and in what they believe are the best interests of the DHB and the Crown as owner
 - ii. the duty to act with reasonable care and skill
 - iii. the duty to not fetter their discretion as to how they will act (e.g., they cannot contract for how they will exercise their voting power in the future)
 - iv. the duty to not place themselves in a position in which their personal interests or duties to other persons are liable to conflict with duties to the DHB, without the informed consent of the DHB
 - v. the duty not to use information that belongs to the DHB for their individual or other purposes without the informed consent of the DHB and not to disclose that information without the informed consent of the DHB (unless the information has already been made public other than through the default of that member)
 - vi. the duty to delegate and monitor the delegations appropriately.
45. In addition, members may have duties arising from other statutes e.g. under the Public Finance Act and the Financial Reporting Act.
46. In recognition of the role being undertaken by Board members, and the duties above, it is proposed that, upon appointment/election, Board members will undertake an approved training programme to prepare them for the role of a Board member.

Liabilities of DHB members

47. Members of the Boards of DHBs, committees of DHBs and staff of DHBs will not be held personally liable for the actions of the Board where they are acting in 'good faith' and 'with reasonable care and skill' in performing or exercising any of these functions, duties or powers. This provision is important as board members will need to manage a number of different considerations:
- i. the best interests of the DHB

- ii. the Government's policy objectives as mandated through accountability documents
 - iii. the interests of the community
 - iv. consumer interests
 - v. Māori aspirations
 - vi. the use of public funds appropriated for a particular purpose
 - vii. the distinction between the governance role and the managerial responsibilities of the Chief Executive.
48. Holding members individually liable may lead to operational issues being inappropriately escalated to the Board for consideration (e.g. implications of decisions for individual patients), and interfere with the ability of the employees of the DHB to perform their duties.
49. Holding Board members collectively accountable, does not however, diminish their responsibility to assume individual responsibility for their contribution to decision making. Current arrangements for HHSs specify individual accountability for bad financial management and it is important that gains made in this area in recent years are not lost. Mechanisms would be established to ensure this accountability.

Sanctions

Dismissal of the whole Board

50. It is important that the Minister of Health has the ability to impose sanctions on the Boards of DHBs should performance be unsatisfactory and where the Minister of Health lacks faith that the board has the ability to improve performance and meet accountability expectations, both to the Minister of Health and to the community.
51. It is anticipated that the Minister of Health will have a range of mechanisms available to influence DHBs whose performance is of concern. These mechanisms, supports, and points of intervention are being considered by the Workstream on Accountability Arrangements (reporting by 31 March 2000). The ultimate power the Minister of Health will have has already been agreed by Cabinet - the ability to dismiss the Board and introduce a Commissioner. The circumstances under which dismissal would occur include repeated performance failure and unsuccessful attempts to address such failures.
52. Appointment of a Commissioner should be considered as a last resort option. The circumstances when a Commissioner should be appointed requires further consideration and further advice on this issue will be provided.

Dismissal of Chair and individuals

53. It is possible that instances will arise which mean that it is desirable to dismiss an individual Board member. Legislation needs to accommodate this potential.
54. Appointed members are on the Board at the pleasure of the Minister of Health and can be dismissed at the will of the Minister of Health.
55. It is suggested that the following are reasons for individual dismissal of elected members:
- i. mental or physical condition affecting adequate or competent performance of the duties and responsibilities of office
 - ii. inability to perform the duties of the office
 - iii. conviction of an offence punishable by imprisonment for a term of two years or more during the term of office of the member
 - iv. absence from four consecutive Board meetings without leave of the Board or Minister of Health
 - v. neglect of duty
 - vi. misconduct

- vii. inadequate performance.
- 56. Grounds for the first four of these are relatively easily established. Similarly, the grounds dismissal for neglect of duty, misconduct and inadequate performance are internationally well established in case law. Although in all instances the person responsible for dismissing a member would need to be satisfied that the grounds for dismissal are well founded. The individual dismissed may have recourse to the Ombudsman or judicial review if they believed the grounds for dismissal were unfounded, options for appeals will be the subject of further work.
- 57. In the context of the Crown Entity governance work the State Services Commission will propose to the Government that grounds for dismissal be simplified and Board members will serve either at the pleasure of the Minister of Health, or, where a degree of protection or independence is appropriate (as where members are elected) that dismissal will be for just cause.
- 58. It is proposed that members who are dismissed from office do not have the ability to be re-elected or re-appointed in the next election/appointment cycle except where, to avoid discrimination a person is subject to a Compulsory Treatment Order or other mental or physical condition.
- 59. Further, it is proposed that Board members who are dismissed will not have a right to compensation for dismissal.
- 60. Before a member was dismissed from the Board for an offence such as inadequate performance, it would be expected that the performance monitoring mechanisms of the Chair would have been used to address performance concerns. Similarly, before the Chair or Deputy-Chair was dismissed from the Board, they could be demoted from Office.
- 61. As the Board is ultimately responsible to the Minister of Health for performance it seems appropriate that the Minister of Health is also able to dismiss the members of the Board - including the Chair and Deputy-Chair. This ability is intimately connected with the combination of elected and appointed members on the Board, the position of chair, and potentially the electoral process.

Combination of elected and appointed members

- 62. The ability for the Minister of Health to dismiss elected members of the Board may be perceived as undermining the democratic election process by which elected members came to the Board. This risk is able to be mitigated through a clear understanding, from the outset, of the collective accountability of the Board to the Minister of Health.
- 63. If a further check on the dismissal of elected members is desired, the Minister of Health could be required to consult with the Chair and/or Board before dismissing an elected member. In any event, grounds for dismissal will need to be established first.

The position of Chair

- 64. The role of the Chair of the DHB is pivotal in ensuring the success and smooth functioning of the entity. It is important that the individual occupying this position has skills commensurate with the responsibility and accountability of the Board.
- 65. There are a two feasible options for establishing a Chair (and Deputy-Chair) each of which have advantages, disadvantages and implications for the dismissal of members:
 - a) Appointment by the Minister of Health from the Board membership (i.e. from among either the elected or Ministerially appointed members).
 - b) Election by the Board members from the Board membership

66. The decision between these options is determined by the degree of control desired over the skills of the Chair, and the degree to which the Government wishes to demonstrate close links with the community, and promote Board autonomy by providing the Board with the opportunity to elect the Chair.
67. While demonstrating a close link with the Community is important, there are concerns with the Board members electing the Chair:
 - i. there is risk that an inappropriate Chair will be appointed which places the functioning of the DHB at risk (and in turn the Crown) and confuses the direct accountability to the Minister of Health
 - ii. evidence from Area Health Boards indicates that having clearly mandated authority in the Chair is important to overall Board function
 - iii. the appointment (and dismissal) of Chair by the Minister of Health is an effective mechanism for the Minister of Health to improve Board performance on a graduated framework of sanctions and interventions
 - iv. the appointment and dismissal of the Chair by the Minister of Health retains the level of control over the Board consistent with the Crown's interest in the DHB.
68. With regard to the dismissal of members, if the Minister of Health both appoints the Chair and has the ability to dismiss members (especially elected members) there is a risk that links with the community are seen to be weaker. A further risk is that, prima facie, the Minister of Health could be seen to be able to undermine the role of Chair by dismissing members on the Board.
69. In practice, this latter concern may not be significant and could be managed through communication channels between Minister of Health and Chair.
70. The strong preference of Officials is that the Minister of Health appoint the Chair and Deputy-Chair of the Board.

The electoral process

71. The ability for the Minister to dismiss elected members raises an issue about the process used to elect members to the Board (detail on the eligibility for election and process issues are discussed in a later section of this paper).
72. There are three processes which could be used to elect members to the Board:
 - i) Preferred members chosen by the community in an election are put forward to the Minister of Health for consideration for appointment. Appointment of preferred candidates would be expected but could be withheld in exceptional circumstances. In addition, the Minister of Health would have a separate process for appointing an additional minority of members.
 - ii) Members chosen by the community in an election are automatically members of the Board. The Minister of Health then appoints an additional minority of members.
 - iii) A third, and middle option requires the Minister of Health to legally appoint all the elected members to the Board before they can hold office.
73. There are both advantages and disadvantages to each of the above approaches. Option b) provides the most transparent process for electing members to DHBs and I propose that the detail of this option is the subject of further work by Officials.

Process for determining Board membership

74. Cabinet has determined that Boards will be made up of a combination of elected and appointed members, and will have equitable representation of Māori. Elected members are to be the majority.

Defined populations and electorates

75. DHBs are to focus on the health and disability outcomes for a defined population of individuals and groups of individuals. Groups of individuals can be defined in a number of ways including, by place of residence (geographic boundary), by the type of services they use (e.g. mental health services), and by their chosen ethnic identity (e.g. Māori).
76. The Government has already determined that:
- i. DHBs will be established to serve populations based on the areas for which HHSs currently provide (the majority of their) services
 - ii. the process of electing members to DHB Boards will be tied to local government elections.
77. These decisions, combined with a number of practical considerations (such as not establishing a separate electoral process for DHBs and maintaining flexibility in the use of population-based funding), mean that geographic boundaries for DHBs are preferred.
78. While HHSs, as the building blocks for DHBs, do not have geographical areas defined for them, it is relatively easy to identify the geographical community of interest they serve.
79. Initial analysis shows that Territorial Local Authority (TLA) boundaries will be the most suitable for DHBs as they: correspond well with the catchments served by HHSs and where issues arise from mismatches with iwi boundaries they can be addressed (as has been the case in other contexts). This approach also allows for the relatively easy implementation of electoral processes, and correspond with existing systems for the collection of health information and demographic data.
80. Further, more detailed, information on DHB boundaries will be provided in due course.
81. Defining DHB boundaries geographically in this way does not preclude DHBs having relationships with populations which are not defined geographically. The following situations would be possible, likely and desirable:
- i. DHBs would be able to purchase services for their populations from providers who span DHB districts for example, Māori providers who span DHB boundaries and provide services for a specific population
 - ii. Cabinet has agreed that one or more DHBs will be able to establish subsidiaries for the regional provision of services, e.g. specialist mental health services
 - iii. co-operative and collaborative arrangements with other DHBs to provide services across DHBs
 - iv. national purchasing of some services if appropriate.

Elected members

82. To meet the Government's objective to have DHBs closely aligned with local community values and perspectives, people elected to DHBs will be drawn from within the DHB district according to their primary residence.
83. The Local Elections and Polls Act 1976 prescribes who may stand for election and who may vote in a local election. It is proposed that these provisions are adapted for DHB elections. In addition the following people should be considered unfit to stand for election:

- i. people convicted of an offence punishable by imprisonment for a term of 2 years or more (unless the person has obtained a pardon, or has served the sentence)
 - ii. any person undergoing treatment for a mental or physical condition that would affect their ability to adequately and competently perform the duties of office
 - iii. any person who is subject to orders made under section 10 or 11 or 12 or 30 of the Protection of Personal and Property Rights Act, or any person in respect of whom a trustee corporation is managing the person's property under section 32 of the PPPR Act
 - iv. people who are undischarged bankrupt
84. People in the employ of organisations such as lobby organisations, and providers could stand for election or appointment to DHBs, but would be expected to declare any conflicts, or potential conflicts of interest, before accepting nomination. This would also apply to employees of HHSs and the HFA for the transitional period.
85. The ability for DHB employees to be able to stand for election to a Board requires further investigation with regard to the precedents set by Local Authorities (whose employees are not restricted in their ability to stand for the Board) and the enormous potential for conflicts of interest to occur. This must be balanced however, by the potential to limit a person's income by requiring that they resign in order to stand on a Board, and the potential for problems in having enough skilled people for Board membership (this may be a particular issue for Māori and Pacific people). Further information on this issue, and the ability for Ministry of Health employees to stand for election will be provided by 31 March 2000.
86. The Public Service Code of Conduct sets out the duties of public servants. It states that public servants are free to stand for, or be appointed to, any office for position on any public or voluntary body. However they should first inform their employer of their intentions, to ensure that no conflict exists between such participation and their duties and responsibilities as a public servant. Where the employer considers that there would be a conflict of interest, appropriate arrangements will need to be made to avoid or resolve the conflict. In some cases this may require that the employee be requested not to stand for office, or to resign a position already held. These provisions will cover employees of the Ministry of Health, for example.
87. It may be that no DHB members are elected or the required number of members are not elected. In this instance, the most appropriate course of action may be for the Minister of Health to appoint additional members to the Board until the next election cycle. These members would have the same rights, responsibilities and accountabilities as other Board members. Alternatively the position could be left vacant. This decision can be made on a case by case basis.

Holding elections

88. It is intended that DHB elections will be held concurrently with local body elections from 2001 and triennially after that.
89. The Local Elections and Polls Act 1976 provides the requirements for the election of members to any office in, under, or in connection with, any local authority required by law to be filled by the election of the electors of any local government area.
90. It is recommended that, in order to minimise transactions costs the process of election of DHB Board members is consistent with the processes established for and the actual mechanisms (administration) used, for local authority elections.
91. Meeting the cost of elections for DHBs will need to be established in consultation with local bodies and would be met by individual DHBs. This process would be similar to arrangements for Regional Councils. Election costs will need to be met from within DHB administration funds and the responsibility for this reflected in legislation.

Appointed members

92. In recognition of the limitations of having solely elected DHB Boards, Cabinet has agreed that the Minister of Health will appoint a minority of Board members, and publish these appointments in the *Gazette*. This aims to ensure an adequate skill mix on Boards, and adequate coverage of Māori interests.
93. People appointed to Boards would not be required to be resident within the DHB district. The exclusions which would apply to people who may stand for election should also apply to people able to be appointed to a DHB Board.
94. In recognition of the number of skilled people available for Board membership, particularly for Māori, it is proposed that appointed members are able to sit on more than one Board.
95. It is proposed that legislation reflect the need for appointed members to be individuals who will 'assist the DHB to carry out its functions and achieve its objectives'. More detailed criteria need to be established to ensure a robust and transparent process of appointment, but these criteria should not be included in legislation. Existing guidelines, such as those prepared by CCMAU for HHSs and the State Services Commission for Crown Entities could be adapted for this purpose.
96. Two key issues need to be considered in developing this profile:
 - i. sound management of the DHB and delivery of its objectives, recognising the level of skill and knowledge commensurate with this position
 - ii. the most appropriate avenue for other community groups (such as Pacific people, mental health consumers etc. to have their needs transparently considered in Board deliberations. Board membership is one avenue for this to occur, other avenues include the development of advisory committees and consultation processes.
97. In order to determine and address skill deficits or gaps in Board membership, the Minister of Health will first need to have the elected board membership confirmed. The Minister of Health will then be in a position to seek advice and appoint additional board members following already established processes. The appointment of members to DHBs will follow the election of members.
98. The detail of these, and continuity timing arrangements (discussed under 'Terms and conditions', will need to be specified in legislation.

Nomination, election and appointment of Māori to DHBs

99. The Government has made a commitment to equitable representation of Māori on DHBs. A paper on Māori partnership issues, submitted concurrently has developed a number of options for ensuring equitable representation which have flow on effects for electoral processes.
100. It is important that the option for equitable representation chosen results in an implementable and practical process for election of members, takes account of the capacity for board positions to be filled and is mindful of the desired number of board members. Each option has associated advantages and disadvantages which are detailed in the Māori partnerships paper.
101. It has been recommended that further work on the practicality of implementing the options is undertaken and that this work inform the choice of option for equitable representation and Māori electoral processes.

102. This work will be completed and reported back on 31 March.

Number of Board members

103. The number of members on each Board will influence that Board's ability to carry out its functions efficiently and effectively, and impact on the administration costs of each Board. A balance needs to be struck between ensuring adequate coverage of the community's interests and Māori interests, skill mix and effectiveness. Experience in HHSs and other Boards has shown that five to seven board members is the ideal number to achieve good performance. This number is likely, however, to be insufficient to ensure adequate skill mix on the Board. If more board members are desired to achieve skill mix goals a maximum of nine members is proposed. The final number of Board members will be determined by the electoral process and the need to ensure skill mix and will be the subject of further work by Officials.

Terms and conditions of Board members

104. In order to facilitate the introduction of new members and to reinvigorate the Boards it is proposed that Board members serve a maximum of six years, made up of two terms of three years. Members may serve longer than six years at the discretion of the Minister of Health, who may wish members to serve longer to ensure continuity of knowledge and skills. Terms of three years have been chosen to coincide with the local body election cycle.

105. Consideration of exceptions would occur through the normal appointments process.

106. It is desirable that the term of office of members be able to be staggered to ensure continuity of knowledge as Board membership changes. This will need to be achieved through the Ministerial appointment processes - these members can operate on different start and finish dates from the elected process. It is suggested that the terms of appointed members begin/finish within six months of the electoral cycle to ensure continuity of knowledge as Board membership changes.

107. In order to attract high calibre candidates, and in recognition of the professional nature of the task required of Board members (with its associated obligations), it is recommended that Board members are remunerated for their services.

108. The remuneration of Board members will vary over time. The legislation should provide for the Minister of Health to set remuneration for Board members. Options for the remuneration of Board members, including the applicability of local government processes, existing guidelines approved by Cabinet and the current HHS process are being considered by Officials.

Disclosure and conflict of interest

109. Some Board members will be appointed or elected because they bring to the Board the benefits of their experience or involvement in activities closely related to the business of the DHB. Because of their backgrounds, therefore, such members may not be free of competing interests and consequently may encounter situations where they face a conflict between their duties to the Board and their activities outside the Board.

110. In general terms the onus for managing conflicts of interest is on the Board or Board member to take appropriate action when they face a potential or actual conflict of interest. A number of documents are available to provide guidance to Board members on how to handle conflicts of interest (e.g. Cabinet Office Circulars, State Services Commission Guidelines, Institute of Directors Guidelines).

111. For the purposes of legislation it is recommended that Board members be required to disclose any actual or potential conflict of interest to the Board and not participate in any

Board discussion or decision relating to the conflict after the disclosure is made. The Local Authority (Members Interests) Act 1968 may provide a useful model for Board members in this regard.

112. The Minister of Health could reserve the power of waiver in appropriate cases, such as where all Board members have a conflict on an issue (which would be extremely rare) to table the issue in the House.
113. Controlling the use of information by Board members for purposes other than Board duties should also be included in legislation.

Procedures of the Board

114. It is proposed that a quorum be established to allow the Board to function and not be frustrated by members excluding themselves from meetings to thwart decisions. This could occur where the appointed members or the elected members decide separately to withdraw from a meeting. The exact nature of the quorum needs to be established and reported back on 31 March.
115. Should establishing a quorum fail and members game to frustrate Board processes, it is recommended that legislation provide a mechanism whereby a 'default quorum' can be established. For example, if the Board meets with insufficient members to establish a quorum the legislation can invoke an automatic meeting of the Board which is advised to all members as being sufficient for decision making (i.e. a potentially smaller quorum).
116. It has been proposed that one avenue to assist with transparency of decision making is to make Board meetings open to the public and media. The Board will, however, need to go into committee on some agenda items (this is the same process as local authority meetings). This process enable transparency around the process for decision making and allow the community to gauge whether their views have been considered in discussion.
117. There are risks with running meetings in this way. The overarching risk is that Board members may 'grandstand' in order to gain public support and be visible in representing a point of view - this type of risk is highest around elected members and may grossly interfere with the functioning of the Board. Another risk is that Board members will be need to go into committee on many agenda items (e.g. if patient information is to be discussed, or important financial decisions made). Board members being in committee may lead to suspicion about decision making in the community.
118. If it is concluded that open meetings are desired, this should not prevent the Board from making decisions by resolution and tabling them at a following Board meeting. This is an efficiency tool which would allow more minor Board decisions to be made without the need to call a public Board meeting.
119. If open meetings are desired, the Local Government Order In Meetings Act provides a potentially suitable model for the conduct of these meetings. If open meetings are desired by Ministers, further advice on appropriate processes can be provided.
120. Other provisions may need to be made in legislation to cover procedural matters such as, vacation of office of both appointed and elected members (e.g. death, conviction), member using another member as a proxy if unable to attend a meeting, calling and holding of meetings, chair presiding at meetings, voting, teleconferences, and other matters.

Employees

121. I propose that a mechanism by which the Government has some role influencing the terms and conditions of employment for employees of Board is developed. The State

Services Commission will propose that the following provisions will apply to all Crown Entities:

- i. that Crown Entities are to be required to consult the State Services Commission (SSC) on Chief Executive terms and conditions of employment
- ii. that Crown Entities be free to negotiate terms and conditions of employment for staff (other than Chief Executive without consulting the SSC unless required to do so by Order in Council).

122. This mechanism provides the Government with a check on the fiscal implications of Chief Executive salaries and collective contracts. The arguments for requiring all or individual DHBs to consult with the SSC about employee terms and conditions will require further consideration.

Governance in the event of a merger or division of a DHB

123. Cabinet has agreed that there may be circumstances where two or more DHBs may choose to merge voluntarily. The merger of boards does not affect the processes already described for the election and appointment of members. Members will be nominated and elected from the new area serviced by the consolidated DHB. The merger of boards does, however, influence the composition of the board in the period between the merger and the next triennial TLA election.

124. Given that:

- i. holding an election for a DHB outside the usual triennial cycle of TLA elections would be very expensive and cumbersome
- ii. widespread voter participation in an election outside the usual cycle is unlikely
- iii. moving from two or more DHBs to one DHB will be a voluntary exercise by the DHBs involved.

125. Thus it is recommended that the membership of the DHB formed by voluntary merger consists of all the elected and appointed members of the merged DHBs until the next election can be held (or fewer members by agreement).

126. In the case of division of a DHB a similar process would be followed, although the Minister of Health may wish to appoint additional members to manage two DHBs, prior to the next election cycle.

127. Legislation would need to provide for the transfer of assets etc. in the event of a merger or division.

Accountability

128. Advice to the Ad Hoc Ministerial Committee on the options for the design of DHB accountability arrangements will be provided by 31 March 2000. The arrangements will include mechanisms to ensure:

- i. clear articulation of the strategic goals and objectives for the health sector
- ii. clear specification/definition of the performance expectations of each DHB
- iii. the appropriate delegation of decision-making powers/authority to enable the delivery of the performance sought
- iv. allocation of resources to reflect the performance being sought
- v. that adequate incentives are in place for DHBs to deliver the performance being sought
- vi. reporting/monitoring of performance against expectations, including benchmarking
- vii. graduated sanctions and monitoring
- viii. sound financial management
- ix. appropriate points of intervention by the Minister of Health.

129. These arrangements will focus on the purchase, ownership and regulatory aspects of DHB performance and will consider the roles and responsibilities of the various players in the health and disability sector including, DHBs, the Minister of Health and Parliament, and the community (including Māori). Accountability to other Ministers, such as the Minister of Finance, will also be considered by this workstream.
130. The issue of developing a mechanism whereby the Board is accountable to the community (on behalf of the DHB) for decisions it has made will also need to be considered by the Accountability Workstream.

Consultation

131. An important aspect of accountability which needs to be reflected in legislation is the requirement that DHBs undertake consultation with the community. While elected members bring a particular set of skills and perspectives to bear in executing the Board's responsibilities which reflect the community's values, this does not supplant the need for consultation as reflected in Cabinet's intention that DHBs will 'consult and exhibit a sense of social responsibility by having regard to the interests of the communities they serve'.
132. The Board would be collectively responsible and accountable for ensuring that the DHB undertakes an appropriate level of consultation with the community. It is recognised that even though the Minister will appoint some Board members, and others will be elected by the community, their position as individual Board members is not to represent, or promote the views of, a particular interest group.
133. It is proposed that consultation requirements similar to those currently in place for the HFA are established for DHBs. The current requirements are that the HFA consult with individuals and organisations from the communities served by it who receive or provide health services, and other persons, including voluntary agencies, private agencies, departments of State and territorial authorities. Consultation is to be undertaken regularly about the HFA's intentions relating to the purchase of services as considered appropriate.
134. A number of issues related to consultation need to be considered in further detail, including, for example, mechanisms to reduce 'consultation fatigue', and provide ongoing input to the New Zealand Health Strategy. Further consideration about processes and requirements of DHBs consult will be undertaken by the Accountability Workstream and reported back by 31 March 2000.

Audit

135. DHBs would be subject to audit provisions as a legislated component of the accountability arrangements. This would include a accountability to Office of the Auditor-General, and accountability under the Public Finance Act. These issues will be considered as part of the Accountability Workstream.

Powers of the Minister of Health and Director-General of Health

136. Current legislation provides Ministers the power to:
 - i. require the HFA to provide financial information (Minister of Finance)
 - ii. direct the HFA on any lawful matter, which may include funding particular services (with the requirement that such direction is given following consultation with the Board and subsequently published in the Gazette and presented to the House of Representatives) (Minister of Health)
 - iii. require the provision of services by HHSs (with the requirement that the Minister consult the HHS and present a copy of the requirement to the House) (Minister of Health).

137. It is recommended that similar provisions are provided for Ministers in relation to DHBs. To mitigate inappropriate use of these powers the requirements that DHBs are consulted by Ministers before the powers are enacted, and that the results of the powers are tabled in the House and published in the *Gazette* should also be maintained.
138. The Minister of Health may also wish to reserve the power to merge DHBs where there are good reasons for doing so. There may be situations where to ensure DHBs are viable, and to take advantage of economies of scale a merger would be desirable. Further consideration of this issue, with regard to accountability and the meeting of performance targets, is needed before this power is proposed.
139. Current legislation also provides powers to the Minister of Health and the Director-General of Health to undertake investigations and inquiries, the recent Cervical Screening Inquiry is a good example. It is recommended that it is in the public interest to carry these provisions over to new legislation. The applicability of the provisions in Section 39 of the Resource Management Act (which allows only the inquiring team to question witnesses and does not allow for cross-examination in court) for DHB inquiries will be considered further by officials. Without this provision inquiries will be very long and expensive. A properly resourced inquiry team will then be able to make findings without the need for a lawyer for every party to do this for the inquiry team.

Board Committees

140. Cabinet has agreed that, as a minimum, DHBs will be required to form:
 - i. a Hospital Governance Committee
 - ii. a Primary Care Advisory Committee.
141. It is necessary that the legislation require Boards to establish these Committees and give them the ability to establish these and Committees. Other types of committees which DHBs may wish to establish include a Māori advisory committee, a mental health services committee, a public health committee, or a disability support services committee. Formation of other committees will be at the discretion of the Board.
142. The Committees will sit beneath the Board and are designed to provide a vehicle for separating the decision making on primary care and hospital care/ownership issues. This separation is particularly important in managing the risk of hospital dominance in Board decisions. The responsibility for managing the resulting tension, and making the necessary trade-offs will rest with the Board.
143. The appropriate membership of the Committees has yet to be determined, and will be in large part driven by the precise role of the Committees. It may be appropriate that the Committees are largely made up of Board members who are encouraged to co-opt other members.
144. The precise roles of the committees, their relationship with the Board, and their autonomy is largely dependent on the degree of devolution of decision making determined in the paper on the roles of DHBs, and the management of service delivery. Operational and procedural provisions for these committees (similar to those for the DHB itself) would apply to committees.
145. Considerable further work on these issues is required and will need to be put to Ministers for consideration.
146. Further advice on this issue, and the equitable representation of Māori on Board Committees will be provided to the Ad Hoc Ministerial Committee as part of the report back on 31 March 2000.

Transitional DHB Boards

147. In the first instance, DHBs will be established with transitional boards which will be in place until the local body elections in 2001.
148. It is proposed that the members of transitional boards are wholly appointed by the Minister of Health.

CONSULTATION

149. This report on governance arrangements for DHBs was prepared by an interagency working group led by the Ministry of Health, and including Te Puni Kōkiri, the Department of Prime Minister and Cabinet, The Treasury, the Health Funding Authority, CCMAU, and the State Services Commission.

FINANCIAL IMPLICATIONS

150. Full identification of the one-off costs and ongoing fiscal impacts of the proposed structural changes, including those related to the establishment and management of DHBs, will be reported by 31 March 2000 [Cab 00 M2/4 refers].
151. The financial implications of the proposals in this paper have not yet been costed but relate to:
- i. the costs of elections
 - ii. any additional costs of Board members (for example, the aggregate number of DHB Board members may be the same or somewhat larger than the current number of HHS directors and HFA Board members, plus the any costs of running the Board's primary care and hospital committees)
 - iii. the administrative and transactions costs associated with Maori partnership arrangements
 - iv. any additional administration costs for DHBs over and above HHS and HFA administration costs
 - v. any additional costs for the training of Board members over and above HHS and HFA director training already budgeted for.

LEGISLATIVE IMPLICATIONS

152. The legislation required forms part of the New Zealand Public Health Services and Health Reforms (transfer and transitions provisions) Bill.

HUMAN RIGHTS ACT 1993

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

REGULATORY IMPACT STATEMENT

154. A Regulatory Impact Statement prepared in accordance with the requirements set out in CO (98) 5 is attached.

PUBLICITY

154. Any publicity on matters related to this paper is being managed as part of the Communications Strategy that forms part of the wider work on health sector change.

CABINET:

- a noted that the submission under SPH (00) 35 was provided in response to the Cabinet direction that the Ministry of Health, in consultation with the Health Sector Development Officials Group, report to the Ad Hoc Ministerial Committee on the preferred options for the organisational form of District Health Boards (DHBs), including the role, accountability and reporting requirements of Board Committees [CAB (00) M 2/4(gg)(iv) refers];
- b noted that the Boards of DHBs will be placed in a position where they feel a dual accountability to both the Minister of Health and the community which elected them and that reconciling the tension created will be a constant challenge for the Board that needs to be managed by creating a strong accountability to the Minister of Health;

EMPOWERMENT AND ESTABLISHMENT OF DHBS

- c noted that Cabinet has agreed that DHBs will be established by a New Zealand Public Health Services Bill (which may be entitled the New Zealand Public Health and Disability Services Bill);
- d agreed that DHBs be listed in the schedule to the Act (following enactment);

Organisational Form

- e agreed that DHBs be established as statutory corporations;
- f agreed that DHBs be Crown entities subject to Part V of the Public Finance Act;
- g agreed that all assets vested in the DHBs will remain in Crown ownership and the DHBs will be consolidated on the Crown balance sheet;

Powers of DHBs

- h agreed that DHBs be established with the full powers of a natural person (of full age and capacity) and that the exact nature and scope of the powers given to DHBs be mitigated by a number of mechanisms;
- i agreed that the risks associated with the exercise of these powers be controlled by clearly outlining the functions of DHBs, limiting the powers of the DHB in statute where appropriate, clear accountability arrangements, transparent Board processes and consultation;

ROLE OF BOARDS

Governance by a Board

- j agreed that the role of the Board is to set strategic direction, appoint the Chief Executive, monitor the performance of the entity and its Chief Executive, ensure compliance with the law, accountability documents and relevant Crown

expectations, and maintain appropriate relationships with the Minister of Health, Parliament and the public;

- k agreed that the Board is responsible for delegating responsibility for employment matters to the Chief Executive as it is not appropriate that the Board is involved in staffing issues beyond the appointment of the Chief Executive;

Prudent Financial Management

- l noted that DHBs and their governing Boards will be in control of, and held accountable for, significant sums of Crown-provided revenue and potentially capital which could expose the Crown to financial risk;
- m agreed that to assist with mitigating the financial risks to the Crown and to protect the Crown's ownership interest, mechanisms to ensure sound financial management, including maintaining financial viability, are included in legislation;

ROLE, RESPONSIBILITIES AND DUTIES OF BOARD MEMBERS

- n agreed that, in order for the Boards of DHBs to achieve their overall objective, Board members (both elected and appointed) will be collectively responsible and accountable to the Minister of Health for DHB performance;
- o agreed that Board members undertake an approved training programme upon taking office as Board members;
- p agreed that Board members be required to disclose any actual or potential conflict of interest to the Board and not participate in any Board discussion or decision relating to the conflict after the disclosure is made;

Liabilities of Board Members

- q agreed that the Board members, Committee members, and employees of the DHB are liable for failing to act in good faith and with reasonable care and skill in carrying out their functions and powers;

Dismissal of the Board

- r noted that Cabinet has previously agreed that the Minister of Health will have the ability to dismiss the entire Board and replace them with a Commissioner in defined circumstances [CAB (00) M 2/4 (m) refers], which will be subject to a report back on Governance by the Health Sector Development Officials Group (paragraph (nnn) below refers);

Dismissal of Individual Members

- s agreed that the Minister of Health have the ability to dismiss individual appointed members at the pleasure of the Minister of Health, and dismiss elected members for just cause;
- t agreed that Board members who are dismissed will not have a right to compensation for dismissal;

THE POSITION OF CHAIR

- u noted that the role of the Chair is pivotal in ensuring the success and smooth functioning of each DHB;
- v agreed that the Minister of Health appoint the Chair and Deputy Chair of each DHB Board;

THE ELECTORAL PROCESS

- w agreed that members chosen by the community in an election are automatically members of a DHB Board, and directed officials to undertake detailed work on the implementation of this option;

APPOINTMENT AND ELECTION OF MEMBERS

- x agreed that DHBs will be defined by geographic boundaries;
- y noted that defining DHB boundaries geographically does not preclude DHBs having relationships with populations which are not defined geographically and may span DHB districts;
- z agreed that the provisions in the Local Elections and Polls Act 1976 concerning who is eligible to stand in an election and vote in an election be used for DHB elections;
- aa agreed that, in addition to the provisions in the Local Elections and Polls Act 1976, the following people are excluded from standing in an election or being appointed to a Board:
 - i people convicted of an offence punishable by imprisonment for a term of 2 years or more (unless the person has obtained a pardon, or has served the sentence);
 - ii any person undergoing treatment for a mental or physical condition that would affect their ability to adequately and competently perform the duties of office;
 - iii any person who is subject to orders made under sections 10, 11, 12 or 30 of the Protection of Personal and Property Rights Act, or any person in respect of whom a trustee corporation is managing the person's property under section 32 of the Protection of Personal and Property Rights Act;
 - iv for the election/appointment cycle following dismissal, any person previously dismissed from office (except, to avoid discrimination, where a person was subject to a Compulsory Treatment Order or suffered a severe mental or physical condition at the time of dismissal);
 - v any person who is an undischarged bankrupt;

- bb agreed that people declare any conflicts, or potential conflicts, of interest before accepting nomination for election;
- cc agreed that, for the transitional period, employees of HHSs and the HFA declare any conflicts, or potential conflicts, of interest before accepting appointment to a transitional Board;
- dd agreed that the ability of DHB and Ministry of Health employees to stand for election, or be considered for appointment, to a DHB Board requires further investigation (paragraph (nnn) below refers);
- ee agreed that the ability of public servants to stand for election should be guided by the Public Service Code of Conduct;
- ff agreed that people should be able to be elected to only one Board;
- gg agreed that, should the required number of elected Board members fail to be elected, the Minister of Health will have the ability to appoint additional members to the Board until the next election cycle, or allow the position to remain vacant until the next election cycle;

HOLDING ELECTIONS

- hh agreed that DHB elections will be held triennially and concurrently with local body elections, and will utilise existing systems and process to minimise transaction costs;
- ii agreed that the cost of elections for DHBs will be met by DHBs;

APPOINTED MEMBERS

- jj noted that Cabinet has agreed that the Minister of Health will appoint a minority of DHB Board members [CAB (00) M 2/4 (k) refers];
- kk noted that the Minister will *Gazette* the appointments referred to in paragraph (jj) above;
- ll agreed that people appointed to DHB Boards are not required to be resident within the DHB district;
- mm agreed that appointed members may sit on more than one Board;
- nn agreed that the appointments process will follow standard and agreed processes yet to be finalised;
- oo noted that further consideration is being given to the options for equitable representation of Maori on DHB Boards and Committees, and that a report back on the most appropriate options will be provided by 13 April 2000 (paragraph (nnn) below refers);

pp noted that final decisions on how disability support services will fit into the new DHB structure, and how they will be represented on boards, have not yet been made, and that recommendations on board representation may need to be revisited after those decisions are made;

NUMBER OF BOARD MEMBERS

qq agreed in principle that DHB Boards have a maximum of nine members, that the number of members on each Board may be variable, and that further work on the detail of the number of members on each Board will be undertaken by officials (paragraph (nnn) below refers);

rr agreed that the appointment of members be staggered to ensure continuity of knowledge within the Board;

TERMS AND CONDITIONS OF BOARD MEMBERS

ss agreed that appointed Board members serve a maximum of six concurrent years, or longer at the discretion of the Minister of Health;

tt directed the Health Sector Development Officials Group to undertake further work on the level of remuneration of Board members, including the applicability of local government processes (paragraph (nnn) below refers);

PROCEDURES OF THE BOARD

uu agreed that mechanisms to achieve a quorum and a “default quorum” be established and reported back (paragraph (nnn) below refers);

vv agreed that Board meetings be open to the public, subject to the normal restrictions applied to local authority meetings;

ww directed the Health Sector Development Officials Group to provide further information on how restrictions on media operate at open board meetings;

xx agreed that standard provisions related to other procedural matters for the Board, eg vacation of office, voting and other standard matters will be included in the DHB legislation or constitution;

EMPLOYEES

yy agreed that the consent of the State Services Commissioner will be required on the terms and conditions of employment of the Chief Executive;

zz agreed that the State Services Commissioner will only be consulted on the terms and conditions of collective employment contracts proposed to be entered into by DHBs if required by Order in Council;

GOVERNANCE IN THE EVENT OF A MERGER OR DIVISION OF DHB

- aaa agreed that, in the event of a merger of two or more DHBs, until the next election can be held, the membership of the Board consist of all the elected and appointed members of the merged Boards or fewer members by agreement;
- bbb agreed that in the event of a division of a DHB, the Minister of Health has the ability to appoint additional members to the Board until the next election cycle;
- ccc agreed that legislation include provision for the transfer of assets and liabilities in the event of a merger or division of DHBs;

POWERS OF THE MINISTER OF HEALTH AND THE DIRECTOR-GENERAL OF HEALTH

- ddd agreed that the Minister of Health have the power to direct DHBs and that checks are put in place to avoid inappropriate use of this power;
- eee agreed that DHBs be required to give effect to Government policy as communicated by the Minister of Health;
- fff agreed that the Minister of Health have the power to require DHBs to produce particular outputs;
- ggg agreed that the powers of the Minister of Finance with regard to DHBs be clarified in the report back on accountability arrangements referred to in paragraph (mmm) below;
- hhh agreed that the Minister of Health and the Director-General of Health have the power to undertake investigations and inquiries with regard to DHBs;
- iii agreed that the provisions in section 39 of the Resource Management Act regarding the questioning of witnesses be investigated as appropriate for inquiries and investigations of DHBs (paragraph (nnn) below refers);

HOSPITAL COMMITTEES

- jjj noted that Cabinet has agreed that DHBs will be required to form, at a minimum, a Hospital Governance Committee, and a Primary Care Advisory Committee;
- kkk noted that the precise roles of these Committees, their relationship with the Board, membership and autonomy is largely dependent on decisions made about the overall role of DHBs, and the management of service delivery, and will be the subject of further advice to the Ad Hoc Committee by 13 April 2000;

TRANSITIONAL BOARDS

- lll agreed that transitional Boards of DHBs be wholly appointed by the Minister of Health;

FURTHER REPORTS

- mmm noted that the officials' accountability workstream will be reporting to the Ad Hoc Ministerial Committee on the detail of accountability mechanisms and the implications for legislation by 13 April 2000;
- nnn noted that further advice on governance, and other issues listed below, will be provided to the Ad Hoc Ministerial Committee by 13 April 2000:
- i DHB Committees – their role, relationship with the Board, membership and autonomy;
 - ii the ability for DHB employees to stand for election, or be considered for appointment to DHB Boards;
 - iii the election of Maori to DHBs and ensuring equitable representation;
 - iv the proposed electoral process;
 - v the roles of other Ministers in relation to DHBs;
 - vi mechanisms for establishing a quorum;
 - vii the circumstances under which a commissioner would be appointed;
 - viii important issues related to effective DHB financial management including defining the long term financial viability and performance expectations for legislation, taxation status, appropriate capital structures, sources of finance and borrowing powers of DHBs, and other matters;
 - ix the detail of DHB boundaries;
 - x the detail of a residual Ministerial power to merge DHBs;
 - xi options for appeal by members dismissed from a Board;
 - xii the use of section 39 of the Resource Management Act;
 - xiii the remuneration of DHB Board members;
 - xiv the number of DHB Board members.

REGULATORY IMPACT STATEMENT

Objective

1. The policy objectives are:
 - i. to ensure sound governance of DHBs commensurate with their role and responsibilities
 - ii. to provide DHBs with an appropriate range of powers, and freedom to manage their affairs, while enabling the Minister to exercise control where necessary and desired
 - iii. to ensure that DHB Boards have clarity over their role and accountabilities
 - iv. to provide appropriate mechanisms for communities to have input into DHB deliberations

Statement of the problem and the need for action

2. The combination of elected and appointed members on DHB Boards creates a perception of dual accountability within Boards: to the Minister of Health, and through elected members, to the community.

Feasible options to achieve the desired objectives

3. The paper concludes that the only feasible option to ensure sound governance is to establish a single, clear line of accountability between Boards and the Minister of Health. Without this it will be very difficult for Boards to manage their affairs effectively and efficiently and manage the dual responsibility they may feel.

Non-regulatory measures

4. The nature of the policy objectives means that there are no viable non-regulatory interventions available

Regulatory measures

5. Governance arrangements for DHBs, and in particular the detail of the establishment, composition and function of the Boards will be included in legislation, or legislation will enable the Minister of Health to determine such arrangements. The proposed governance arrangements will be captured in the New Zealand Public Health Services Bill

Statement of the net benefit of this proposal

Benefits

6. The key benefit of having a single line of accountability between DHB Boards and the Minister of Health is that Boards will be in a position to be able to balance the many, potentially competing considerations which will arise:
 - i. the Government's policy objectives as mandated through accountability documents
 - ii. the interests of the community
 - iii. consumer interests
 - iv. Māori aspirations
 - v. the long term interests of DHBs
 - vi. the use of public funds appropriated for a particular purpose

Costs

7. The cost of having a single line of accountability is the potential for concern from the community and elected DHB Board members that the community's views have not been adequately taken into account and their preferences reflected in the purchasing of

services. This can be managed through strong accountability arrangements between the Minister and DHBs which include a requirement to establish strong links with their communities.

Consultation

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