OFFICE OF THE
MINISTER OF HEALTH

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

DHB GOVERNANCE: DISTRICT HEALTH BOARD COMMITTEES

PROPOSAL

1. This paper proposes that both DHB Committees required by Cabinet (CAB (00) M2/4) are established in an advisory role subordinate to the DHB Board. The Health Improvement Advisory Committee is proposed to provide strategic advice on health gain, and the management of the interface between primary and secondary care. The Hospital Governance Committee is proposed to provide oversight of and monitor the performance of the hospital and to advise the DHB Board on performance accordingly.

EXECUTIVE SUMMARY

2. Cabinet has agreed that DHBs will be required to form, as a minimum, a Hospital Governance Committee and a Primary Care Advisory Committee (refer CAB(00)M2/4).

3. The Minister of Health has also clarified that there will be a single Chief Executive for each DHB who will be responsible for the management of all of the DHBs functions, including the delivery of services by publicly owned hospitals.

4. Within these parameters, Officials consider that both of the committees should be established as advisory committees to the DHB Board. The two advisory committees will allow:

   i. the DHB Board sufficient 'head-room' to focus on its governance responsibility without being involved in the day to day operations of the DHB
   ii. internal mechanisms within the DHB structure to minimise the risk that either of the 'interest' in the DHB (in particular the management of the hospital) predominate over the DHB's overriding responsibility for improving the health of its population
   iii. the distinct ownership and purchase interests within the DHB to be made explicit.

5. It is proposed that a committee known as the Health Improvement Advisory Committee provide advice to the DHB Board on issues related to the prioritisation of services in order to achieve health improvement for the DHB's population. This committee aims to mitigate the risk of hospital dominance in the DHB by taking an overarching view of health improvement, which by definition includes examining the role of primary care, disability support, public health and other more community focused services.

6. It is proposed that the Hospital Governance Committee be charged with advising the DHB Board on the performance of the hospital(s) and strategic issues related to the delivery of hospital-based services. This committee would not be involved in the day-to-day management of the hospital(s) as this is the job of the Chief Executive and the management structure below the Chief Executive.

7. The membership of the committees should be determined by the DHB Board who should have the ability to appoint whatever membership they consider to be required to achieve the task in hand. Officials envisage that this would include a majority of Board members and external expertise as required. The DHB Board maintains the overall responsibility for the form and function of the committees within the parameters set by legislation.

BACKGROUND

8. On 9 March 2000 the Ad Hoc Ministerial Committee on Health Sector Change (the Ad Hoc Committee) considered advice on the high level governance structure for DHBs and agreed on a number of key points. Subsequently, Cabinet also directed Officials to undertake further work on the roles, membership and relationships of the DHB Committees [CAB(00)M11/1A(3) refers]. This paper presents the results of that work.

DHB COMMITTEES

9. DHB Boards will have the overall responsibility for working within allocated resources to achieve positive health and disability outcomes for a defined population and will provide the strategic direction to ensure that these gains are made. The Board will appoint a Chief Executive who will be responsible for the management of *all* the DHB's functions including the delivery of services by publicly owned hospitals.

10. Within this framework, Cabinet has agreed that DHBs will be required to form, as a minimum, a Hospital Governance Committee and a Primary Care Advisory Committee [refer

CAB(00)M2/4]. The requirement to form these committees and the ability to form other committees (if desired by DHBs) will need to be reflected in legislation.

Purpose of DHB Committees

11. Officials understand that there are three reasons for establishing the committees:

    i. to facilitate the Board in undertaking its business and providing 'head room' for it to focus on its governance responsibility as opposed to management of service delivery (and in particular, the day-to-day management of the hospital). This also recognises that the Boards' new role is complex, challenging and new

    ii. to ensure that there are internal mechanisms within the DHB structure to minimise the risk that either of the 'interests' in the DHB (in particular the management of the hospital) predominates over its over-riding responsibility for improving the health of its population (which will include agreements with a wide range of providers not necessarily owned by the DHB); and

    iii. to recognise the distinct ownership and purchase interests the Government has within the DHB.

12. Subsequently, the Minster of Health has clarified that there will be only one acceptable model for senior-level management within DHBs ''*this model provides for a single Chief Executive for each DHB and Primary Health and Hospital Governance sub-committees as a minimum (as is set out in Labour Party policy). The Chief Executive will be responsible for the management of all of the DHB's functions, including delivery of services by publicly owned hospitals*''[1] DHBs will, however, be free to develop their own structures for management below the Chief Executive level.

13. The Ministers' letter is designed to ensure that Officials do not provide advice beyond a managerial separation between the hospital and the rest of the operations of the DHB. The letter does not seek to clarify the purpose and options for the two DHB committees.

14. This paper clarifies the purposes of the committees and their relationship with the DHB Board and Chief Executive within the broad structural parameters defined by the Minister.

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[1] Letter from the Minister of Health to Dr Poutasi, 16 March 2000

Analysis

15. The fundamental issue is that the DHBs are clear about their responsibilities both for health improvement for their populations and for ensuring that Crown owned hospitals and related services are run in an efficient and sustainable manner.

16. The risks, if these two roles are not clearly identifiable in the operations of the DHB, is that the DHB pursues short term goals (e.g. preserving the services delivered by its hospital) instead of focusing on arrangements which would better contribute to long-term improvements in the population's health.

17. Ministers have, through the requirement to form committees, indicated a desire to recognise these different, and potentially competing, interests in the DHB and to manage these interests appropriately.

18. The Minister of Health has indicated that the Chief Executive will be responsible for the management of all the DHB's functions, including the delivery of services by publicly owned hospitals.

19. Within this organisational framework, Officials need to further define the committees' responsibilities to ensure that their functions lead to maximum overall health improvement and that this is done in an even handed manner between providers owned by the DHB (ie its hospitals) and providers not owned by the DHB (eg primary/community providers).

20. Prior to discussion of the preferred option for committees there is a need to be clear on some aspects of the committees roles.

Primary Care Committee

21. It is our understanding that the rationale for establishing the ''primary care committee'' is to ensure that community providers receive even-handed treatment with the DHB-owned hospitals, and to address the complex interface between primary and secondary care. The most effective way of achieving this goal is by focusing the committee's purpose on advising on the best health interventions the DHB could make to achieve overall health improvement for the DHB's population. A key challenge in this task will be focusing on the improvements to be made in preventing inappropriate hospital admissions through primary care interventions.

22. The committee will need to take a broad perspective when considering health improvement. One of the issues the committee is likely to advise on is the need to bring about better

co-ordination across the primary/secondary care interface. At the same time it must be recognised, for example, that disability support services and aspects of public health play an equally important part, alongside personal health services, in maintaining and developing health and well-being in populations.

23. Accordingly, the Committee would focus on the needs of the population and priorities for utilising scarce health funding (within the framework of the New Zealand Health and Disability Strategies). This role avoids undue focus on the inputs into the delivery of health care (ie 'who provides services') at the expense of health improvement, although commenting on relationships with other providers could be a subordinate advisory role of the committee.

24. Given the proposed role of the committee the next question concerns its membership. There are two basic options:

    i. community and provider representatives (that is, independent of the DHB Board); or
    ii. a small subset of DHB Board members and if required external people who can advise on prioritisation, interpreting the requirements of the NZ Health strategy etc.

25. Officials favour the latter option; that is that the members of the primary care committee should be drawn from the DHB Board, and externally if required, to advise on prioritisation, health improvement or any other aspect of the committee's work. In short, its primary focus is on prioritisation and the choice of its membership is determined by the capacity to effectively deliver such advice. This has the advantage in lifting the focus of the committee to ''what's best for the community'', rather than what is best for individual providers and is more consistent with the Government's desired policy outcomes. This is not to say that this committee would not consider community values in its deliberations and may well consult or co-opt this skill to achieve this end.

26. Finally, assuming that this committee has this broader focus, Officials consider that it makes sense to clarify its role through its name and propose that Ministers consider changing the name to the Health Improvement Advisory Committee.

Hospital Governance Committee

27. The role of a hospital *governance* committee also needs clarification. The governance role (such as that played by the DHB Board itself) normally means high level strategic oversight of an entity which is managed by a Chief Executive. It is clear from

the Minister's letter that the hospital will not be separately governed in this way (ie with a separate Chief Executive for hospital operations) within the DHB.

28. In an organisation where the Chief Executive has the total responsibility for all operations of the DHB, the Hospital Governance Committee should have no role in the direct management of hospital services delivery.

29. The key issue with regard to the role of the Hospital Governance Committee thus is whether this committee should advise the DHB on hospital governance issues, or play an active part in the governance of the DHBs hospital(s). More specifically:

    i. a committee that advises the DHB on hospital governance issues and has a purely advisory/oversight role, that is, it monitors the performance of the hospital (and related services) and proffers advice to the Board on the performance of the hospital and related services; or

    ii. a committee that plays an active part in the governance of the DHB's hospital(s), that is, it sets the strategic direction for the operation of the hospital and plays a key role in managing the performance (via the Chief Executive) of the hospital.

30. Under both of these options, operational responsibility for all aspects of the DHB's operations (including for the hospital) will reside with the CEO who is directly accountable to the DHB Board.

Finance and Audit Committee

31. Irrespective of the precise number, roles and relationships of the DHBs' committees, each DHB should be required, as part of good governance practice, to establish a Finance and Audit Committee. The requirement to establish this committee however, need not be established in legislation.

Options for DHB committees

32. There is scope for a variety of arrangements to increase transparency around the DHB's funding and service delivery functions, and to minimise the likelihood of the DHB's interest in its own hospital overriding its other objectives.

33. Officials have considered a number of models and applied the following criteria in assessing the relative merits of each committee model:

i. facilitating the Board to meet its overriding responsibility to promote health gain within allocated resources
ii. creating clear lines of accountability within the DHB
iii. consistency with the responsibilities of the Chief Executive for managing the DHB and the responsibility for the Board in governing the DHB
iv. minimising the cost of the Board in undertaking its functions
v. allowing for effective integration of primary and secondary services in meeting the DHBs overall health objectives

34. Officials have concluded that there is one option which can best meet the identified objectives. This is shown below in Figure One. It establishes both the Health Improvement Advisory Committee and the Hospital Governance Committee in advisory roles subordinate to the DHB Board. This clearly identifies that it is the responsibility of the Board to govern the DHB and to seek advice from (at least) these committees in fulfilling its governance function.

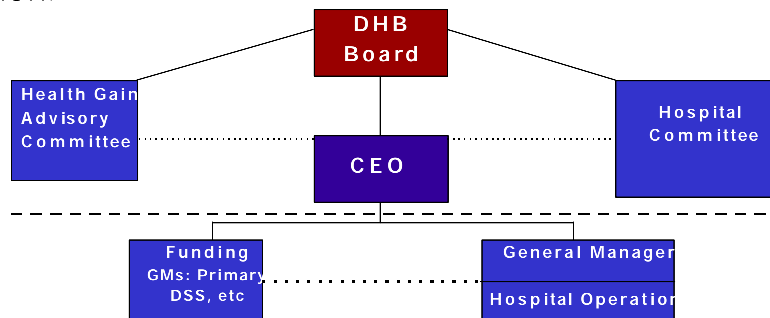

Figure 1: Health Improvement Advisory Committee and Hospital Governance Committee advise the DHB Board[2]

Committees

35. Both committees would function in an advisory capacity to the Board (as specified by a broad statement in regulation) but this would not preclude committees, from time to time, being given delegated authority (without delegated accountability) from the Board to advise on specific issues. This would particularly be the case when such issues might otherwise consume a disproportionate share of the Board's time or other resources. The limits of such delegation would be clearly specified and could be withdrawn by the Board at any time. This ability to delegate reflects the overall accountability of the DHB Board for the governance of the DHB and the right of the Board to control its committees.

36. The committees would have the following features:

[2] Note: the management structure below the Chief Executive (below the dotted line) is indicative only and will be a matter for the DHB Board to determine.

i. they would be structured as normal board committees. That is, they would act within delegated powers from the DHB Board and will be fully accountable to the DHB Board. The degree of delegation, over and above their advisory role, would be determined by each DHB Board.

ii. any recommendations or decisions of the committee will need to be ratified or rejected by the DHB Board (unless the ability to make decisions has previously been delegated). The DHB Board will be legally accountable in all areas for the performance of the organisation.

iii. the committees can normally provide advice only to the DHB Board and they may only give advice or release information to other parties under authority from the DHB Board or at the request of the Minister

iv. the processes/rules for of committees (for example, to convene meetings) would be determined by the DHB Board as part its constitution.

Health Improvement Advisory Committee

37. It is proposed that the Health Improvement Advisory Committee provide advice to the DHB Board on how the Board should meet its overall health improvement and independence objectives. It would provide the Board with advice on the mix and range of services (''primary'' and secondary'' in the broadest meaning of those terms) to meet those objectives.

38. This committee could also provide a link with the New Zealand Health Strategy and the New Zealand Disability Strategy in that it could help the Board interpret the local implications of the nation-wide and sector-wide health goals and performance expectations. It could give useful advice on strategies to reduce disparities in health status.

Hospital Governance Committee

39. Officials recommend that the Hospital Governance Committee should fulfil an overview role and provide advice to the Board on the performance of the hospital. This Committee will not govern the hospital in the sense of being accountable for the performance of the hospital. The Chief Executive is accountable to the Board and the Board is accountable to the Minister for the performance of the hospital.

40. The Hospital Governance Committee would advise the DHB Board on the hospital's performance. The Committee would monitor hospital activities against pre-determined financial and service delivery targets and recommend sanctions if necessary. It would also give advice on the strategic issues associated with the provision of hospital services. It would not be responsible for actively managing the running of the hospital. The Chief Executive would probably choose to appoint a General Manager to run the hospital on a day-to-day basis (although such decisions should be made at a local level).

Roles of DHB and Chief Executive

41. The structure described above provides for a clear separation between the overall governance function of the DHB Board and the purely advisory responsibilities of the committees. There is also (and vitally) clarity around the accountabilities of the Chief Executive.

42. To avoid confused accountabilities for the Chief Executive, he/she must be held accountable (directly to the DHB Board) for all operational and management issues relating to the hospital and other DHB provided services.

43. If the committees were able to make binding decisions on behalf of the DHB Board, the Chief Executive would have to also be accountable to the committee(s), which could potentially be at conflict with the Board, other than where this authority has been explicitly delegated by the Board.

44. This would not prevent, in the interests of information flow, the Chief Executive (or their staff) having a relationship with both advisory committees. In practice, the Chief Executive may well attend committee meetings as a observer. Notwithstanding the formal accountability line to the DHB Board officials envisage that the Chief Executive will also have a reporting relationship with the Hospital Governance Committee on DHB provider related issues in order to inform the advice the Hospital Governance Committee proffers to the DHB Board.

Other committees

45. It is possible that other committees of the DHB Board will be required to enable the DHB Board to adequately discharge its responsibilities, but this is a matter for each DHB Board to determine.

46. The preferred structure provides for two advisory committees. It would be possible for a further committee made up of

representatives of providers to be established to provide a distinct vehicle for non-DHB providers, such as iwi providers, primary care providers and NGOs to offer input to the DHB Board. However, the *requirement* to include a specific provider-focused committee may create tension within the organisation vis a vis its hospital arm and risks slowing down greater integration of community and secondary care. Requiring the development of another advisory committee also has the disadvantage of requiring DHBs to set up a number of committees which may not be appropriate for smaller DHBs; and raises overall administration costs.

47. Instead of requiring the establishment of further committees, Officials recommend that DHBs be able to set up other committees as they see fit. If a DHB needed detailed provider input, therefore, it could set up an informal (ad hoc) arrangement to receive input, from time-to-time.

Conclusion

48. Officials consider that, given the parameters already set, the structure and relationships between the committees, the DHB and the Chief Executive should be as follows:

    i. *Health Improvement Advisory Committee* advises the DHB Board on health improvement priorities and the prioritisation process for health services for the DHB population. A relationship is maintained with the Chief Executive, but this is not an accountability relationship

    ii. *Hospital Governance Committee* advises the DHB Board on the hospitals performance. In assessing hospital performance it would need to monitor the hospital against the performance expectations set in the annual plan and other relevant accountability documents. A relationship is maintained with the Chief Executive who may be required to provide reports to the Hospital Governance Committee on hospital performance in order to inform performance monitoring.

    iii. The DHB Board may also delegate authority to the Hospital Governance Committee to undertake specific tasks.

    iv. *Chief Executive* maintains overall accountability to the DHB Board for the management of the DHB. The Chief Executive will function as directed by the DHB Board.

    v. *The DHB Board* maintains its governance capacity to focus on high level strategic issues and to receive advice on these matters from its committees.

50. It is proposed that a review of the effectiveness of the DHB Committees in fulfilling their functions and assisting the DHB Board in managing the DHB occur periodically. To allow for any review of the roles of the DHB Committees to be easily reflected in their future operation it is proposed to establish the requirement to form committees in legislation and their overarching objective in regulation. Any review of committees would occur in the context of overall sector and DHB performance monitoring.

51. Officials have not discussed how the DHB organises itself internally at a managerial level since this is not likely to be a matter for legislation and will be the responsibility of the Chief Executive. It is recognised however that this will be important for the effectiveness of the system. It is expected that there would be a strong internal separation between planning/funding and service delivery with service level agreements linking the two sides of the DHBs operations.

Size and Membership of Board Committees

Size

52. The size of committees should be determined by the Board and will be constrained by the overall budget of the Board.

Membership

53. Given the overall accountability of the DHB Board, all positions on the DHB committees should be appointed by the DHB Board. The Board is likely to form committees with a majority of Board members with external appointees as required for skill mix. Committees should also be able to obtain additional advice as and when required.

54. Actual membership of the committees would reflect the overarching objectives as detailed in regulation, and the decision that committees will have equitable representation of Mäori (CAB(00)M2/4 refers).

55. It is not desirable that the detailed composition of committees is spelt out by Government, as each DHB will be different and will have to establish committees which are fit-for-individual-purpose, for example the needs of the West Coast DHB Committees may not be identical to the needs of Auckland Central DHB. The Government will expect, however, that the DHB Boards appoint committees with the skills, experience and expertise to ensure that they receive sound advice.

56. Cross membership between the Hospital Governance Committee and the Health Improvement Advisory Committee within one DHB should be excluded, or restricted, but at the discretion of the Board. The reason for this is to ensure that the streams of advice objectively reflect the two 'interests' in the organisation (this constraint need not be extended to other committees the Board may establish, including the Audit and Finance Committee). Given the possible skill shortages within DHB Boards it is appropriate to give the Boards flexibility in this regard recognising that they will be accountable for ensuring that any committee member does not undermine the focus and function of the committee.

Committee meetings

57. Cabinet has decided that DHB Board meetings will be open to the public [CAB(00)M11/1A(3)vv refers]. It is likely therefore that committee meetings should also be open to the public to avoid DHB Board issues being inappropriately considered by committees in order to keep them out of the public arena. If committee meetings are open to the public, the committees will need to reserve the right to 'go into committee' on particular agenda items.

CONSULTATION

58. This report was prepared by an interagency working group led by the Ministry of Health, and including Te Puni Kökiri, DPMC, The Treasury, the Health Funding Authority, CCMAU, and the State Service Commission.

FINANCIAL IMPLICATIONS

59. Full identification of the one-off costs and ongoing fiscal impacts of the proposed structural changes, including those related to the DHB Committees, will be reported back in the final paper on fiscal implications in May.

60. The financial implications of the proposals in this paper have not yet been costed but relate to:

    i. payment for members to sit on Board committees
    ii. committee functions (holding meetings, producing reports etc)

LEGISLATIVE IMPLICATIONS

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

HUMAN RIGHTS ACT 1993

62. There are no Human Rights Act 1993 implications in this paper.

REGULATORY IMPACT STATEMENT

63. A Regulatory Impact Statement prepared in accordance with the requirements set out in CO (98) 5 prior to submission to Cabinet is attached.

PUBLICITY

64. 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 options for District Health Board (DHB) committees have been considered:

within the parameters set by Cabinet decisions that there will be two DHB committees [CAB (00) M 2/4 refers]; and

according to the Minister of Health's letter to the Director-General of Health, which states: "*this model provides for a single Chief Executive for each DHB and Primary Health and Hospital Governance sub-committees as a minimum (as set out in Labour Party policy). The Chief Executive will be responsible for the management of all the DHB's functions, including delivery of services by publicly owned hospitals*";

b agreed that the two committees - the Hospital Governance Committee and the Primary Care Advisory Committee (see paragraph (g) below) - undertake an advisory role to DHBs;

c agreed that the DHB Board be able to delegate its powers to a committee on the basis that the DHB Board remains accountable for any action taken by that committee;

d agreed that the Chief Executive be accountable for all the operations of the DHB (including the hospital(s)) and be directly accountable to the DHB Board for exercising this function;

e noted that the role of the DHB Board is to provide governance, strategic oversight and overall accountability for the DHB to the Minister of Health;

f agreed that, to avoid confusion about the Chief Executive's responsibility to the DHB Board, the committees be subordinate to the DHB Board and decisions of the committees will be ratified or rejected by the DHB Board except where the Board has explicitly delegated authority;

HEALTH IMPROVEMENT ADVISORY COMMITTEE (PRIMARY CARE ADVISORY COMMITTEE)

g agreed that the "Primary Care Advisory Committee" referred to in paragraph (b) above, be known as the "Health Improvement Advisory Committee", recognising that the interest of this committee is wider than primary care provision, and includes all services required by the DHB population;

h agreed that the focus of the Health Improvement Advisory Committee be to provide advice to the DHB Board on the needs of the population and priorities for utilising scarce health funding (within the framework established by the New Zealand Health and Disability Strategies);

i noted that the focus referred to in paragraph (h) above aims to ensure that the best interventions (both primary and secondary focused) are adopted by the DHB in order to achieve overall health improvement for the DHB's population;

j agreed that the membership of the Health Improvement Advisory Committee be chosen by the DHB Board;

k agreed that the DHB Board will be responsible for ensuring an appropriate mix of skills and expertise on committees;

l agreed that the Health Improvement Advisory Committee be able to obtain external advice as necessary in fulfilling its functions;

HOSPITAL GOVERNANCE COMMITTEE

m agreed that the Hospital Governance Committee focus on:

monitoring the performance of the hospital (and related DHB-owned services);

strategic issues associated with the provision of hospital services;

and provide advice and recommendations to the DHB Board in this regard;

n agreed that the membership of the Hospital Governance Committee be chosen by the DHB Board;

o agreed that the Hospital Governance Committee be able to obtain external advice as necessary in fulfilling its functions;

OTHER ISSUES

p agreed that cross-membership between the Hospital Governance Committee and the Health Improvement Advisory Committee within one DHB should be excluded, or restricted at the discretion of the Board (this constraint need not be extended to other committees the Board may establish, including the Audit and Finance Committee);

q agreed that DHB Boards be required to establish an Audit and Finance Committee, but that this requirement not be included in legislation;

r agreed that DHB Boards can establish other committees as they see fit;

s agreed that a review of the effectiveness of the DHB Committees in fulfilling their objectives occur periodically;

t agreed that, to allow for any review of the roles of the DHB Committees to be easily reflected in their future operation, the requirement to form committees be reflected in legislation and their overarching objectives in regulation;

u noted that officials have not discussed how the DHB organises itself internally at a managerial level since this is not a matter for legislation and will be the responsibility of the Chief Executive;

v agreed that DHB Hospital Governance Committee and Heath Improvement Advisory Committee meetings should be open to the public.

Hon Annette King
Minister of Health