

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

**THE DIVISION OF ROLES BETWEEN DISTRICT HEALTH BOARDS AND THE
MINISTRY OF HEALTH**

PROPOSAL

1. I propose that DHBs should ultimately be responsible for the planning and funding of all health and disability support services, with the exception of those determined by the Government.

EXECUTIVE SUMMARY

2. Cabinet [CAB (00) M11/1A refers] has previously decided that:
 - i. DHBs will be accountable for funding or providing the mix of services which ensures the best health and independence outcomes for their populations, within available funding
 - ii. DHBs will move to a state where they have a high degree of autonomy, but will start out in a highly regulated and prescribed environment
 - iii. The Minister of Health (assisted by the Ministry) will play a strong leadership and monitoring role: DHBs will work within the parameters of the New Zealand Health Strategy, the New Zealand Disability Strategy, and nationwide requirements that will form part of Funding Agreements.
3. This paper focuses on the ultimate division of roles. In the transition the Ministry of Health is expected to be accountable for the planning and funding of a number of services to give the transitional DHBs the chance to develop. I propose that, apart from exceptions identified by the Government, DHBs will ultimately be responsible for planning and funding all health and disability support services, so that:
 - i. DHBs have an unambiguous accountability for funding the best mix of health and disability support services for their populations, within budget
 - ii. local users and communities have a greater say over health and disability support services
 - iii. any conflict of interest between the Ministry of Health funding services and funding and monitoring DHBs is minimised.
4. Unavoidably, given that DHBs are responsible for a geographic area, some providers will provide services for more than one DHB. Within nationwide frameworks, each DHB must understand and pursue local needs and preferences, and will need the skills and resources to do so. This does not

mean that DHBs should aim to deliver all services themselves: DHBs will need to closely collaborate in relation to certain services.

5. It would be inappropriate for some services to be planned or funded by each of the 22 DHBs on an individual basis, because concerns are that:
 - i. regional or national organisations may face additional administration costs from multiple, complex contracts with many DHBs, and some services require much inter-district co-ordination
 - ii. some small DHBs may find it difficult to manage within budgets when faced with exceptional or unpredictable high-cost services
 - iii. parts of the disability sector feel that DHBs may not be appropriate funding agencies, because disability issues are different from health care, and DHBs may put low priority on disability support services
 - iv. some small DHBs may find it difficult to plan for services that are rare or require specific expert knowledge
 - v. development in Māori, Pacific, and mental health, and in disability support, may be put at risk without national management.
6. Regulation, accountability arrangements (including funding agreements and monitoring), and powers to direct (if required) give the Minister of Health powerful means to support achievement of necessary co-ordination, specific performance standards and policy objectives. The Ministry of Health will support DHBs through service frameworks and policy guidelines, provision of information and expert advice, and facilitation.
7. For a small number of health and disability support services, however, planning and/or funding functions are better undertaken regionally or centrally. This may be done by the Ministry of Health or through DHB collaborative arrangements. There is no systematic way, however, to identify what the best option is without being able to compare actual proposals for DHB collaborative arrangements with the alternative of direct funding of specific health and disability services by the Ministry of Health.
8. However, removing funding responsibilities for some services from individual DHBs raises serious risks, namely:
 - i. confusion on who is accountable for prioritisation and improving health and independence of DHB populations – the DHB or another agency
 - ii. greater potential for cost-shifting between multiple funding streams, for example by redefining secondary services as tertiary services
 - iii. a conflict of interest between the Ministry of Health funding services and funding and monitoring DHBs
 - iv. barriers to local service coordination and integration
 - v. reduced responsiveness to local needs, preferences and opportunities.

Unintended consequences could include poorer decisions on service mix and levels, and budget overruns.

9. For these reasons, I recommend that, as principles:
 - i. all health and disability services funding should be indicated to DHBs before allocation to any regional or national budget. This will ensure DHBs are aware of which services they contribute to and their costs
 - ii. if services need to be planned or funded for at a regional or national level, then, as far as possible, such arrangements should keep DHBs accountable for performance.
10. The enhanced HHS boards will report to the Minister of Health by 1 September 2000 with proposals for DHB shared services, and national and regional funding alliances. The HFA, CCMAU and the Ministry of Health will work with the boards on those proposals. I propose that officials report back in November on those plans so that the Ministers of Health and Finance can assess:
 - i. whether the Boards' proposals will be effective at addressing the concerns of additional administration costs and coordination, or whether other funding arrangements should be imposed
 - ii. which specific responsibilities for planning and/or funding services should be retained in the Ministry of Health
 - iii. what the process and timing should be for devolving all other planning and funding functions to DHBs, guided by the criteria and processes that will be set out in the DHB development framework to be reported to the Minister of Health by November 2000 [CAB (00) M11/1A refers].
11. The Director-General has set up a DHB Establishment Unit within the Ministry's Sector Funding & Performance Directorate. This unit, incorporating staff from the Ministry and the HFA and with formal links to other central agencies, will work closely with HHSs and the DHBs once they are established.
12. The Ministry of Health, following consultation with officials, will provide a further report on funding options specifically for disability support services. In November, officials will also advise Ministers on enhanced HHS board proposals to address the concerns around disability issues, and the timing of devolving DSS functions.

BACKGROUND

13. This paper advises on a more detailed service-by-service division of roles between District Health Boards (DHBs) and the Ministry of Health [CAB (00) M 11/1A]. The focus is on the ultimate division of roles, not that during the transition.
14. It also covers report-backs on the development of Māori service capability, national and tertiary services, disability support, services for DHB cooperation,

and Ministry of Health accountability arrangements in respect of funding providers directly [CAB (00) M2/4, M11/1A (4) and M11/1A(3) refer].

15. Advice on potential services for cooperation is limited to the planning and funding-related functions of DHBs, which includes needs analysis, prioritisation, co-ordination, entering into agreements with providers, monitoring providers, and making payments. It excludes DHB back-office functions or service delivery related functions (for example, information technology and procurement of supplies) as those matters will be covered in the DHB Establishment project.
16. Decisions to date on the role of DHBs and the Minister of Health are that:
 - i. DHBs will be accountable for funding or providing services which ensure the best health and independence outcomes for their populations, within available funding. DHBs will decide, therefore, on the mix, level, and quality of health and disability services within nationwide guidelines
 - ii. initially the DHBs' environment will be highly regulated and prescribed but DHBs will move to a high degree of autonomy according to specific criteria and processes
 - iii. the Minister of Health will play a strong role by setting (in consultation with DHBs) the strategic direction and outcomes sought, national minima and guidelines, and by using reserve powers to intervene in DHBs sparingly.
17. Concerns have been raised by groups in the sector that, for some services, it would be inappropriate to place planning and funding responsibilities with individual DHBs, and that these are better placed with a regional group or a central organisation. The main reasons put forward are that:
 - i. some services are provided nationally or regionally (for example, tertiary services and telephone helplines). Some local services are provided by national organisations (for example, IHC, Family Planning and Plunket). Providers are concerned that they will face additional administration costs if they have to have complex contracts with many DHBs
 - ii. some services require a lot of coordination. For example, some public health activities need a consistent approach or co-ordination between districts (for example, screening, and buying and storing vaccine)
 - iii. some services are very costly (relative to a DHB's budget) and the need is very unpredictable or rare (for example, multiple organ transplants or epidemics). Officials have identified that this can make it difficult for some DHBs to manage within their budgets
 - iv. parts of the disability sector feel that DHBs will not be an appropriate funding agency for DSS, because disability support is different from health care, and that DHBs may marginalise and underfund disability support services because they have a narrow medical focus

- v. some small DHBs may find it difficult to plan services that require specific expert knowledge
 - vi. capability in funding and providing health and disability support services in Māori, Pacific, and mental health, and in disability support services is developing. Groups in the sector are concerned that progress may be jeopardised if action is not managed coherently across the whole sector.
18. However, splitting planning and funding responsibilities for some services from DHBs could:
- i. create confusion on which agency is accountable for improving health and independence of a DHB's population, the DHB or another agency
 - ii. introduce greater potential for cost-shifting between multiple funding streams, for example by redefining secondary services as tertiary services, or chronic personal health conditions as disabilities
 - iii. introduce a conflict of interest between the Ministry of Health funding services and funding and monitoring DHBs
 - iv. put in place barriers to local service coordination
 - v. reduce responsiveness to local needs, preferences and opportunities.
19. Unintended consequences could include poorer decisions on service levels and mix (so that people do not receive the best services for their circumstances) and budget overruns. The advantages and disadvantages of the potential options are therefore assessed in accordance with the following framework.

FRAMEWORK TO HELP ASSESS THE DIVISION OF ROLES

20. The starting point is that each DHB will be responsible for planning and procurement of all health and disability support services (within the parameters set by the Minister of Health). This is consistent with previous decisions that gave:
- i. DHBs an unambiguous accountability for funding the best mix of health and disability support services for their populations, within budget
 - ii. local users and communities a greater say over health and disability support services.
21. Unavoidably, these arrangements go hand-in-hand with some providers having to deal with more than one DHB – for example, about 15% of current secondary and tertiary services discharges from a HHS pertain to people from other HHS areas; more than half of these 'cross-boundary flows' occur between the Greater Auckland HHSs. Each DHB must understand and pursue local needs and preferences, and will need the skills and resources to do so. This does not mean that DHBs should aim to deliver all services themselves: DHBs will need to closely collaborate in relation to certain services.

22. The Minister of Health will use accountability arrangements and policy to coordinate service planning. For a small number of health and disability support services, planning and funding functions are better undertaken regionally or centrally by a DHB collaborative arrangement (such as a funding team working on behalf of some or all DHBs) or in some cases by the Ministry of Health. There is no systematic way, however, to identify what the best option is without being able to compare actual proposals for DHB collaborative arrangements with the alternative of direct funding of specific health and disability services by the Ministry of Health.
23. While DHBs must closely collaborate on certain services, this may be onerous, particularly for smaller DHBs. There will also be scope for conflict when it comes to agreeing on allocation of budgets. These matters could draw DHBs' attention away from other areas for improvements in health and independence and reducing disparities. Responsibilities will only be devolved to DHBs in accordance with the DHB development framework, setting out the criteria and process by which individual DHBs will move to the maximum degree of autonomy [CAB (00) M11/1A].
24. Alternatives to DHBs being responsible for funding-related functions will be considered if there are highly compelling benefits, which will clearly outweigh the risks, according to the following criteria:
 - i. consistency with Treaty of Waitangi principles
 - ii. benefits from concentrating planning and funding services
 - iii. benefits from planning and funding different services together
 - iv. significant reduction in contract or negotiations costs
 - v. improved coordination within the sector or with other sectors
 - vi. significant benefits from standardisation or quality control
 - vii. management of fiscal risk to the Crown.
25. The division of roles should contribute to the Government's objectives for the health and disability support sectors – improving the health and independence of the population, reducing disparities, and improving community participation in health and disability support – in the most effective and least-costly manner. This means that arrangements should be based on the needs and preferences of users of health and disability services and local communities, not historical delivery patterns or the convenience of providers, DHBs or central agencies.
26. Service delivery patterns will change as the result of technological advances and consumer expectations. In addition, during the transition to DHBs more specific information will come to hand. Decisions flowing from this paper, and the principles that underpin these, will provide a guide to the detailed allocation of current HFA tasks during the transition.

TYPICAL PROBLEMS AND TYPICAL SOLUTIONS

27. The issues in paragraph 16 are addressed in turn under the following headings:
- i. single services which cover the populations of more than DHB
 - ii. services which are costly and unpredictable
 - iii. disability support services
 - iv. service areas which are developing.

Single services which cover populations of more than one DHB

28. Concerns have been raised that some providers may face additional administration costs if they have to enter into complex agreements with many DHBs, and that DHBs will incur administration costs from managing cross-boundary flows or funding coordination. These concerns pertain to:
- i. services which are provided by only one provider for a number of districts or for the whole country, for cost, quality or historical reasons (for example, tertiary services, health helplines, Equipment Management Services, and forensic mental health services)
 - ii. local services which are provided by regional or national non-government organisations (for example, IHC Family Planning and Plunket)
 - iii. services which require a lot of coordination (for example, some health promotion activities, screening, and the purchase and storage of vaccines).
29. Options to address these concerns are: to fund such services separately through the Ministry of Health; to separately fund a regional or national DHB arrangement; to give DHBs the responsibility to initiate solutions; and/or to have the Ministry of Health facilitate or lead the planning of some services and use accountability arrangements (such as the funding agreement and operating environment and powers to direct) to ensure DHBs fund services accordingly.

Separately funding some national services/organisations

30. It is possible to identify and separately fund specific services, particularly if DHBs have little control, in practice, over the use of low volume and high cost tertiary services (such as lung transplants), and if these services risk conflict between DHBs. A significant separation of funding has disadvantages:
- i. it would undermine the integrity of DHBs to fund the best mix of health and disability support services for their populations, by reducing the clarity of this role and DHBs' ability to respond to local needs
 - ii. it creates opportunities for DHBs to shift responsibility for funding a service to another agency (cost-shifting) by redefining services that would have been paid from their own budgets to fit the criteria of other

funding streams. People could 'fall through the cracks' and services would be harder to coordinate

- iii. the emergence of local providers would be stifled if national organisations are funded centrally. This may be particularly relevant for health and disability services for Māori and Pacific people. Over time, similar services may well be offered by local providers, instead of national organisation or to fill gaps in areas where national organisations have a low presence
- iv. it is not clear that separate funding of some services would save administration costs. A single national contract would save a provider additional administration costs, but those costs would be shifted to the Ministry. That is because the Ministry (or a national DHB arrangement) would still need information from, and would need to negotiate and coordinate with, each of the DHBs
- v. the Ministry of Health may take on too many varied, and potentially conflicting, functions. Performance of its core functions (policy advice, monitoring the sector and DHBs, administration of the regulatory environment, and ministerial servicing) may be inhibited if the Ministry also undertakes significant detailed service funding.

DHBs and providers initiate solutions

31. DHBs and providers will both have incentives to reduce administration costs. They can do so, for example, by developing standard base contracts; agreeing a framework to deal with cross-boundary flows; and/or by setting up a regional or national funding team funded by and working for some or all of the DHBs. HHSs (with the HFA and the Ministry of Health) have already set out on a process to think about DHB collaboration. The HFA and Crown Health Association have a memorandum of understanding to support a partnership relationship for this purpose. In the recent past, HHSs and the HFA have worked collaboratively on a national purchasing framework, including nationally consistent service definitions, prices, and contracts.
32. The advantage of this approach is that it puts DHBs in control of, and accountable for, finding the best funding and coordination solutions. This way, DHBs and providers can develop agreements that suit specific local circumstances. DHBs and providers can build from the HFA's arrangements, including current contracts, which will roll over while DHBs are established.
33. Disadvantages are that standard base contracts or frameworks may not always suit local circumstances. This might be the case, for example, if contracts are designed around the needs of more powerful DHBs. This risk can be mitigated by DHBs having the ability to 'opt out' of the standard contract; DHBs would only want to incur additional costs of re-designing a contract if that would advantage their population.

Ministry of Health initiates nationwide contracting and service frameworks

34. The Ministry of Health will be assisting DHBs by maintaining and developing policy, contracting, and service frameworks. For example, DHBs would find it easier to collaborate on cross-boundary flows or joint funding teams if prices were based on a national pricing framework (building on the HFA's current service pricing framework). The Ministry of Health could also provide other administrative infrastructure to reduce DHB costs, such as developing standard base contracts, forecasting and actuarial services. This reduces potential conflict between DHBs and providers if the Ministry is seen as objective.
35. A key issue is that the Ministry may be too removed from the operational issues and does not face the same incentives as DHBs and providers who must work within budget. DHBs must therefore be closely involved and have ownership of the solutions; often the Ministry would be better to facilitate. From time to time, the Ministry of Health will need to take responsibility for coordination, for example, when central leadership is required to put emphasis on a policy priority or to manage specific fiscal or quality risks. DHBs would still fund and/or deliver the services but would operate within a centrally-led framework.
36. The current Health and Disability Services Act 1993 has a section (s51) which enables acceptance of payment by a provider (for services provided) to constitute acceptance of the funder's terms and conditions. These terms and conditions are notified either publicly or individually. These notices have been used extensively in primary care contracts: more than 16,000 notices have been issued. The savings in administrative costs on funding agencies and on the providers have not been quantified, but are large. Officials recommend that s51 of the Health and Disability Services Act 1993 be adopted in the new legislation for use by DHBs and/or the Ministry of Health.

Using DHB accountability arrangements

37. The Minister will also use accountability arrangements to support the achievement of necessary co-ordination or to encourage or require administrative cost-saving initiatives. For example, funding agreements could contain nationwide minimum service coverage requirements (such as lung transplants or vaccine schedule) and funding ring-fences that apply to all DHBs. Such requirements (formulated in consultation with DHBs and forming part of their funding agreements) will reduce potential areas for conflict among DHBs.
38. The use of accountability arrangements has the advantage of maintaining the integrity of the DHB model. It also avoids the disadvantages of separate funding or any risks that DHB-initiated solutions do not meet expectations. It does rely, however, on DHB compliance and performance. Another distinct risk is that the DHB environment becomes so specified that its efforts on local initiatives and services are stifled: specification could flow over to areas that would be more appropriately the responsibility of DHBs.

Recommendations regarding services that cover populations of more than one DHB

39. DHBs can take responsibility for funding regional or national services and regional or national organisations (acting in a collaborative manner where appropriate). For a small number services, however, it may be that planning and funding functions are better undertaken by the Ministry of Health. There is no systematic way, however, to identify which option is best, without being able to compare actual proposals for DHB collaborative arrangements with the alternative of direct funding of specific health and disability services by the Ministry of Health.
40. As part of the transition management, the enhanced HHS boards will be reporting to the Minister of Health by 1 September 2000 with proposals for DHB shared services, and national and regional funding alliances. The HHS Boards will work with the HFA and the Ministry of Health on this. To provide a formal basis for managing establishment issues, the Director-General has set up a DHB Establishment Unit within the Ministry's Sector Funding & Performance Directorate. This unit (incorporating staff from the Ministry and the HFA and with formal links to other central agencies) will work closely with HHSs/DHBs.
41. I propose that officials report back to the Ministers of Health and Finance in November 2000 on whether those proposals will be effective to address the concerns raised, whether or not funding arrangements should be imposed, and for which services responsibility will be retained in the Ministry. Potential candidates include the planning and/or direct funding of national advisory groups, such as the Laboratory Services Advisory Group, the General Practitioners Group, some high cost and low volume tertiary services, some national services, and arbitration mechanisms on cross-boundary disputes.
42. During the transitional period, the Ministry of Health will fund a number of services whilst DHBs are being established. All service planning and funding functions (apart from a small number of exceptions) will be devolved to DHBs in accordance with specific criteria and the processes which are to be reported to the Minister of Health by November 2000 [CAB (00) M11/1A]. The exact division of roles at the outset of the transition will depend on Ministers' assessment of the transitional plans presented by the enhanced HHS Boards.

Costly and unpredictable services

43. Small DHBs could find it difficult to manage within budget if an exceptional need arose for a very costly service. Examples include multiple organ transplants or epidemics. A past specific example is the Overseas Treatment Fund which was centrally held for Area Health Boards: eventually this fund was distributed (through the population-based funding formula) to the six specific Area Health Boards affected, and these Boards were expected to manage it. The main options are that either DHBs or the Ministry of Health manages these types of financial risks.

DHBs manage the risk of exceptional needs

44. Regardless of whether or not responsibility for all services is allocated to DHBs, DHBs will have to set up risk-reserves, like the HFA has now. DHBs could set up arrangements to manage financial risk individually or jointly – for example, by managing a risk reserve, by borrowing, or by buying insurance. DHBs could be compelled, through the operating environment, to have an appropriate risk-management strategy in place for exceptional needs.
45. Advantages of DHBs managing financial risks are that: it is consistent with DHB accountability for funding the best mix of services within its budget, and avoids cost-shifting to the centre. It ensures that DHBs are aware of both the human and the financial benefits and costs of all services. That would encourage DHBs to fund the most effective services to prevent, manage, or address disease and disability. It also reduces the potential that local prioritisation and clinical issues are escalated to the Minister.
46. A key risk is that DHBs may run deficits and force Government to top up funding. Such behaviour can be mitigated by monitoring and credible sanctions. Very small DHBs may find it hard to establish a risk-reserve if the risks are large relative to its budget; by working together, DHBs could spread the risks and so reduce individual costs.

Ministry of Health manages risks of exceptional needs

47. The Ministry of Health could manage the risks instead, by funding specific services directly when they occur. This means that, in effect, the Ministry is the insurer, reimbursing DHBs when clearly defined, exceptional instances arise. The Ministry would fund such services from Vote Health either on a pay-as-you-go basis or from a risk reserve. This is a credible option only if it is unambiguous whether an exceptional instance arose and if DHBs have no control over exceptional cases.
48. The advantage of direct central funding of defined services is that it may reduce the Crown's fiscal risk because, through 'pooling risk', it makes planning for rare and unpredictable services more actuarially sound, and makes it easier for DHBs to manage their remaining budgets. The administration may also be cheaper and convenient than DHB-based options.
49. Disadvantages are that, because DHBs would not face the costs directly, the separate risk-fund would create potential for cost-shifting, as often it will be difficult to be sure whether a service is an exceptional case. It may reduce DHB awareness of, or incentives to reduce or seek innovative solutions to, the incidence of these conditions. It may also encourage inappropriate escalation of local prioritisation and clinical decisions to Ministerial level.
50. On balance, I recommend that DHBs be responsible for managing the financial risk of services which are costly and unpredictable, recognising that and under specific circumstances risks would need to be managed by the Crown. The Ministry of Health will design detailed risk management requirements on DHBs

as part of their operating environment (which is the set of policy rules and non-legislative regulations that circumscribe what a DHB can, must or must not do). This would also define specific circumstances in which risks would be managed by the Crown. The funding report-back will consider the practicalities of risk-adjustment techniques as part of the population based funding formula, particularly for small DHBs.

Disability support services

51. A major concern raised by parts of the disability sector is that DHBs will not be an appropriate funding agency, because DHBs with a medical focus will be preoccupied with health issues. It is feared that this would result in disability support services being given a low priority in planning, funding, or service development, and that funds may be diverted inappropriately to health services (particularly if the ring-fence is removed). A related concern is that DHBs would not understand disability issues, and may not have the skills to respond to the diverse needs of people with physical, sensory, intellectual, psychiatric and age-related disabilities, particularly for some groups of people with highly complex special needs.
52. Some of these concerns arise from a misunderstanding of the role of DHBs – DHBs will in fact be required to focus on the broader determinants of health and independence, recognising the importance of linkages with other social services (such as housing, transport, income support, education, employment, as well as vocational and child protection services). Such linkages are particularly important in removing the barriers to independence and participation. The concerns about disability support being given low priority are similar to those raised in relation to primary care and Māori health services. The reports on DHB governance, Māori issues, and DHB accountability arrangements set out the means that will be used to mitigate the risks.
53. Other concerns raised are that some regional and national non-government organisations may have to enter into complex agreements with many DHBs, and that there could be a detrimental dilution of service planning and funding expertise. The means to mitigate those concerns are addressed in the sections on ‘single services that cover populations of more than one DHB’ and ‘developing capability’.
54. Other potential means to ensure that DSS has an appropriate identity are:
 - i. DHB accountability mechanisms
 - ii. central funding through the Ministry of Health
 - iii. alternative local arrangements, such as a community board.

DHB Accountability mechanisms

55. Ministers will use accountability arrangements to make clear what is expected of DHBs in relation to DSS, and ensure that DSS has an appropriate identity in DHBs and that the DHBs carry out their responsibilities to improve

independence of, and/or enable participation by, people with disabilities in their districts, as set out in the funding agreements.

56. The advantages of this approach are that it makes DHBs clearly accountable for improving both the health and the independence of a given population, and keeps DSS funding integrated with health funding. This integration (although protected by ring-fences) has helped integration with health services, although more progress can still be made. It has reduced confusion in accountability that existed particularly between health and social welfare, with implications for service fragmentation and gaps.
57. Using the accountability arrangements allows concerns to be mitigated by:
 - i. establishing clear goals and objectives for DSS
 - ii. placing clear accountability and reporting requirements on DHBs, including specific funding requirements
 - iii. monitoring the performance of DHBs.
58. For example, the Minister would expect DHBs to demonstrate how they will contribute to the goals and priorities for disability services identified in the New Zealand Disability Strategy, such as how DHBs would forge strong local links with income support, employment, education, housing and transport services.
59. Where necessary, the Minister would also require DHBs to work within national service specifications, guidelines, protocols, targets and bench-marked performance standards, to be consistent with the DSS framework and the New Zealand Disability Strategy. The Ministry of Health would play a strong role developing frameworks, and facilitating and working with DHBs to plan for DSS services; the Ministry would not need to fund disability services directly. DHB funding agreements could also contain specific funding requirements so that DSS funds are protected from diversion to health services.
60. The enhanced HHS Boards will be reporting to the Minister of Health in September with proposals for how the (transitional) DHBs plan to address the concerns around service coordination and administration costs. Proposals should also discuss how specific concerns around DSS would be addressed, which may well include DSS subcommittees and regional DSS planning/funding alliances. The Minister of Disability issues will write (with the Minister of Health) to the HHS Boards to ensure disability issues are addressed in proposals.

Central funding through the Ministry of Health

61. Disability support could also be funded separately by the Ministry of Health (or another central agency). Under this approach, both planning and funding for disability support services would be separated from health services which will be funded through DHBs.
62. Advantages of separate central funding would be that it could help give disability support a stronger identity at the central-agency level, and could strengthen efforts to achieve a nationwide consistent philosophy for, and

approach to, the funding of DSS services. It could help strengthen intersectoral linkages, and save some costs by combining planning and funding expertise. It would protect DSS funds from diversion to health services (although it would also inhibit desirable prioritisation of funding between health and disability support services). However, all these advantages could also be secured through using DHB accountability mechanisms.

63. The major disadvantages of separate central funding are that it would confuse accountability, and inhibit coordination with health services. Some groups of people with disabilities do not require health services any more than other healthy people. Others, however, require an ongoing mix of health and disability support services which need to be coordinated. This applies particularly to the frail elderly, people with complex disabilities requiring regular medical interventions and people with degenerative medical conditions. In such situations health services and DSS are complementary and integrated services are vital for consumers' wellbeing. Consumers could experience barriers and delays in their movement between health and disability support services (for example following discharge from hospital), if funding for DSS is administered by a separate agency. This coordination can be better achieved at a local level rather than nationally.
64. A related option would be to separate age-related disability and mental health disability from other disability groups, and fund age-related and mental health disability support services through the DHBs (because of the linkages with health) and services for other disability groups via the Ministry of Health or other agency. However, as 51% of DSS spending is in relation to older people (and this proportion is growing), there would be a question about the effectiveness of the residual funding function, given the small size of the budget, the need to link to health services, and the inflexibility of national organisations.

Alternative local arrangements, such as a community board for disability issues.

65. A third option would be to fund disability support services through a local structure parallel to DHBs. The advantage of this option is that it recognises that service planning and funding is best done close to the consumer. A longer-term scenario may see such an arrangement develop into a one-stop social services shop for people with disabilities. The disadvantages, however, are similar to those set out for separate central funding by the Ministry of Health. Significant additional disadvantages of this option would be the additional administrative costs of duplicating local arrangements, and the risk that it would make DSS funding ineffective (particularly in brokering effective links with health organisations) because of the small size of the operation.
66. Regardless of the approach, Ministers have a number of governance and accountability levers available to give a clear identity to disability issues and to drive national consistency and performance in DSS. These are:
 - i. the New Zealand Disability Strategy, to articulate priorities and expectations

- ii. DHB funding agreements, to set down specific performance accountabilities for disability issues that DHBs are monitored on
 - iii. appointments to the Boards, to ensure the board has knowledge of disability issues where this is lacking
 - iv. the provision to set up additional advisory committees of DHB boards, to give disability issues a clear identity by setting up a disability issues committee
67. The Minister for Disability Issues, and the Minister of Health as the shareholding Minister, will write to the enhanced HHS boards to ensure that the boards' transition plans will include proposals for how they would address disability issues.
68. To be able to assess a wide range of funding options that reflect the nature of disability issues, I have directed the Ministry of Health (following consultation with other officials) to submit a further report to the Minister for Disability Issues and Minister of Health, on funding options for disability support services.

Developing capability

69. The capability in funding and providing health and disability support services is still developing in relation to Māori, Pacific and mental health, and disability support services. Development requires co-ordinated and sustained action, and this may be at risk if scarce skills and resources, such as the Māori provider development fund, are spread among all DHBs. (The Māori provider development fund is a separate fund for the funding of Māori delivered services.)
70. The issues are how to maintain a viable funding capability (that is, how to manage a temporary shortage of skills), and how to ensure progress on provider/service development.
71. A shortage of skills would be perpetuated if the function is taken away from DHBs. DHBs need a mandate to understand the total health and disability needs of their populations. A preferred strategy, therefore, would be that DHBs are expected to develop the necessary capability. This would complement the requirement that DHBs do a comprehensive needs analysis for their districts. DHBs could work with other DHBs in their region that have the capability.
72. With respect to Pacific people's health, there are already encouraging signals that the Auckland HHSs are working together in preparation for their DHB role. It is expected that the Ministry of Health will facilitate development of Pacific capability in other key areas through information sharing, its relationships and accountability arrangements.
73. Development of DHB capability in the key areas of mental health, disability support, Māori health and Pacific health will be managed primarily through accountability arrangements. DHBs could be supported by the relevant Ministry of Health branch during the developmental stage. The accountability

arrangements enable the Minister of Health to temporarily take on a more hands-on role where there are performance concerns.

74. An issue is who should administer the Māori provider development scheme, currently administered by the HFA. In principle, DHBs have the best local information and incentives to administer the provider development scheme appropriately. It is also important that DHBs take responsibility for ongoing development. However, dividing this small fund of approximately \$10m among 22 DHBs will leave each DHB with little dedicated resources to seed new Māori providers. For this reason, it is likely that the Ministry of Health will administer this fund, to which DHBs with aspiring providers can apply with their proposals for Māori initiatives, according to well-established criteria for the use of grants, although this should not detract from DHBs' role in provider development.

ACCOUNTABILITY ARRANGEMENTS: THE MINISTRY AS SERVICE FUNDER

75. In my paper on DHB accountability arrangements I indicated that there would be further advice on accountability arrangements for the Ministry of Health in respect of its role in direct funding of providers. During the transitional phase the Ministry of Health will have responsibility for funding health and disability support services, for monitoring the performance of providers in relation to these contracts, and for assigning contracts to specific DHBs over time.
76. After the transition, the Ministry of Health may also continue to have a limited services funding role for specific health and disability support services, to be specified by the Government. For clarity, the New Zealand Public Health Services Bill will need to include a provision for the Ministry of Health to be able to directly fund health and disability support services in such cases.
77. This services funding role will conflict with the Ministry's policy advice role and its monitoring of DHBs and create a risk that the Ministry will not monitor its own spending on services rigorously enough. To manage this risk, I propose that, as a minimum, there will be a specific output class in the Ministry's estimates. Additional monitoring requirements can best be designed when Government has specified which particular services will be funded by the Ministry of Health on an ongoing basis. If the Ministry's service funding turns out to be of a material amount then there would need to be put in place some separation between the service funding and monitoring functions – for instance, a subsidiary funding group – in order to maintain accountability. It will also be necessary to keep DHBs involved in decisions.
78. I recommend that Ministry of Health spending on health and disability services will be funded through a separate output class in the Ministry's Estimates of Expenditure. I also recommend that the Ministry of Health, the State Services Commission, and The Treasury report back to joint Ministers on accountability arrangements for each health and disability support service to be funded directly on an ongoing basis by the Ministry of Health, with an initial report back by the end of November 2000, to ensure that:

- i. there is a clear definition of the health and disability support service to be funded directly
- ii. non financial and financial monitoring arrangements are sufficient for the purposes of service delivery and financial control
- iii. conflicts of interests between the Ministry's planning, policy, funding and monitoring roles and dilution of DHB accountabilities are minimised.

EXCEPTIONS IDENTIFIED TO DATE

Pharmaceutical budget

- 79. Pharmaceutical expenditure (for non-hospital pharmaceuticals) is influenced by PHARMACs activities. On behalf of all DHBs it will manage the Pharmaceutical Schedule, which involves: deciding which drugs to list (subsidise); determining criteria for access to subsidy; and negotiating with pharmaceutical companies over prices and subsidies. DHBs may also exert influence over pharmaceutical expenditure through local service mix decisions and the incentives and controls they put in place in contracts with service providers, but historically the impact of these actions has been small.
- 80. Currently PHARMAC manages the Schedule to meet pharmaceutical budget targets set by the HFA. In future, DHBs would be accountable to manage within their budgets including spending on pharmaceuticals. However, PHARMAC needs to have a clear aggregate expected pharmaceutical budget to work to, particularly when making investment and divestment decisions on the Schedule. DHB accounts would be charged for pharmaceuticals used by their populations, so DHBs would still face the actual costs, and hold and manage their own funds.
- 81. The process of setting the pharmaceutical budget will be as follows. PHARMAC would consult with DHBs over the general direction of pharmaceutical expenditure management and specific transactions likely to affect expenditure. The Minister of Health would then set the 'notional pharmaceutical budget' to which PHARMAC will work. This target will be based on forecasts from PHARMAC of levels of demand driven growth, likely savings and potential new investments.
- 82. PHARMAC would inform DHBs of their forecast share of this notional pharmaceutical budget. However, DHBs will be accountable for managing their own actual pharmaceutical budgets. DHBs could adjust their budget for their own financial management purposes – it would not lessen DHBs' ability to adopt their own strategies, subject to the nationally consistent Schedule, for influencing expenditure on pharmaceuticals to get the best health outcomes. Thus each DHB could spend more or less than the forecast amount provided by PHARMAC.
- 83. Each DHB will therefore face correct incentives to get the best value for money (in terms of health improvement) from the money they spend on

pharmaceuticals. It also gives DHBs access to scarce forecasting expertise, so reducing administration costs and forecasting risk in an area that makes up 10-12% of Vote Health. PHARMAC is likely to have the best information on the impact of its activities on spending, particularly as individually DHBs will have little impact on pharmaceutical expenditure. It also ensures that the national pharmaceutical expenditure that PHARMAC is managing to is consistent with DHBs' budgets.

84. I recommend that the Ministry of Health will advise the Minister of Health on the 'notional pharmaceutical budget requirement' to which PHARMAC will work in managing the Pharmaceutical schedule. Setting that budget follows a process of consultation with DHBs and forecasting by PHARMAC. I also recommend that, in future, DHBs will be advised of PHARMAC's forecast of expenditure for their population, but that each DHB will be responsible for managing their pharmaceutical expenditure within their whole population-based funding budget allocated to them, and will be charged for actual pharmaceutical expenditure of their population.

National Screening

85. New Zealand currently has three national screening programmes: the National Cervical Screening Programme; Breastscreen Aotearoa; and new-born screening. Tight co-ordination, nationally consistent services, high quality standards and nationally consistent information collection and monitoring of quality are essential to maximise the benefits of national screening programmes.
86. National co-ordination of screening programmes is important if they are to achieve their objectives of reducing mortality and morbidity. This can be achieved by specification of requirements or standards in funding agreements with DHBs (and DHBs coordinating their activities in line with such standards), and/or by setting up a single coordination unit. To ensure nationwide consistency, planning and funding for the three current, and any future, national screening programmes is best located in a single co-ordination unit.
87. Such a unit can either be funded jointly by the DHBs (as a team in one DHB, or through a subsidiary organisation) or by the Ministry. The preference is for it to be closely aligned with DHBs, to maintain clear lines of accountability, and to ensure the coordination of funding of screening programmes with treatment services. Decisions on future arrangements for national screening programmes will be made at a later date, when it can be ascertained how this will be managed within the DHB environment and when the results of the Gisborne Cervical Screening Enquiry are known. In the interim the existing unit will transfer into the Ministry of Health.

Public health legislative functions

88. Public health and biosecurity *legislative* functions are undertaken by designated enforcement officers. These officers are accountable to, and

subject to direction from, the Director-General of Health for the implementation and enforcement of legislation on environmental health, toxic substances, communicable disease control, food safety and biosecurity. When the need arises, these functions require a high level of co-ordination and consistency (for example, in the application of the law), as well as technical support from the Ministry of Health.

89. Arrangements should recognise that designated enforcement officers of public health and biosecurity legislative functions, although funded by DHBs, will on occasion be directed by the Director-General of Health (under the Health Act 1954).

TREASURY COMMENT

90. Treasury agrees with the proposals that DHBs should be responsible for planning and funding all health and disability support services, with rare exceptions in compelling circumstances. However, in focusing upon the role of the Ministry of Health in the transition and in the longer term, the paper gives no impression of when DHBs will become fully responsible for purchasing. In addition, other potential options for the transition, such as setting up a central or regional DHB function during the transition, are not given sufficient consideration.
91. The current paper proposes a transitional period of indeterminate length during which DHBs will not have responsibility for a wide range of health and disability support services' planning and procurement. The paper proposes that detailed decisions on which services DHBs should have responsibility for, and which not, will be able to be made on the basis of a November 2000 report back.
92. There are a number of policy risks with this approach:
 - i. once roles pass to the Ministry of Health, it will be difficult to shift them to the DHBs, particularly if the Ministry is handling issues capably
 - ii. unless the transition is time-limited, there is no pressure on either the Ministry or the sector more widely to move to the end-state set out in this paper. Treasury recommends that the transition be completed by the beginning of 2002/3 financial year
 - iii. a development strategy is required which will enable all DHBs to take on the required roles in a defined time. DHBs will find it impossible to demonstrate the capacity without being given the responsibility
 - iv. it is not clear that more *evidence* will be available in November 2000 to guide decisions on the allocation of roles between DHBs and the Ministry of Health. Instead, Ministers may be faced with competing proposals as to where in the system different services should be planned and procured.
93. The current paper discusses the issue of how the Ministry of Health should be held accountable for its planning/procurement/funding role in respect of those services which it will be made responsible for during the transition to fully

functioning DHBs and the narrower set for which it may have responsibility in the longer term. In practice, the Ministry will be acting as a twenty-third DHB and accountability arrangements should be designed to reflect this. The Ministry's 'DHB' functions must be separately identified and separately managed. It is particularly important that the functions are discharged entirely separately from the Ministry's funding and performance management functions in relation to the DHBs.

94. The Treasury acknowledges the importance of a strong leadership and monitoring role for the Ministry of Health under the new DHB structures but also emphasises that this does not necessarily require that the Ministry of Health assume a strong *funding* role within the new structures.

CONSULTATION

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

FINANCIAL IMPLICATIONS

96. Officials will report back on the financial implications as part of the report back in May on the financial implications of the health sector changes.

LEGISLATIVE IMPLICATIONS

97. A number of the recommendations will inform the drafting of the New Zealand Public Health and Disability Services and Health Reforms (Transfer and Transitions Provisions) Bill.

COMPLIANCE COSTS STATEMENT

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

REGULATORY IMPACT STATEMENT

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

HUMAN RIGHTS IMPLICATIONS

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

PUBLICITY

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

CABINET

DIVISION OF PLANNING AND FUNDING ROLES

- a agreed that District Health Boards (DHBs) will progressively move to the appropriate degree of devolved responsibility for planning and funding health and disability support services, as determined by the Government;
- b noted that the Minister of Health can, if required, use accountability arrangements and powers to direct to achieve necessary co-ordination among DHBs, as well as specifying performance standards and policy requirements;
- c noted that the planning and funding of some health and disability support services is better undertaken regionally or centrally by collaborative DHB arrangements, or in some cases by the Ministry of Health;
- d noted that the enhanced Hospital and Health Service (HHS) boards will be reporting to the Minister of Health by 1 September 2000 with DHB transition plans which will include proposals for collaborative DHB arrangements such as national and regional health and disability services funding alliances;
- e directed the Ministry of Health, in consultation with the Treasury, State Services Commission, Crown Company Monitoring Advisory Unit, Department of the Prime Minister and Cabinet and Te Puni Kokiri, to advise the Ministers of Health and Finance and the Cabinet Committee on Social Policy and Health (SPH) by the end of June 2000 on:

the advantages and disadvantages of the DHB transition plans;

which specific health and disability services funding responsibilities might be undertaken by collaborative DHB arrangements, and which by the Ministry of Health (following the framework that is discussed in the paper attached to CAB (00) 319;

how planning and/or funding responsibilities for all other health and disability support services will be devolved to DHBs following their establishment, including a timetable, according to the DHB development framework which will set out the criteria and the process to steer the transition;
- f noted that a DHB Establishment Unit has been set up by the Director-General of Health, within the Ministry of Health, to incorporate staff from the Ministry and the Health Funding Authority (HFA), maintain formal links to the other central agencies and work closely with HHSs/DHBs;

- g agreed that formal responsibility for managing DHB establishment issues rests with the DHB Establishment Unit referred to in paragraph (f) above;

DISABILITY SUPPORT

- h noted that the following governance and accountability levers are available to give a clear identity to disability issues and to drive national consistency and performance in disability support services:

the New Zealand Disability Strategy, to articulate priorities and expectations;

DHB funding agreements, to set down specific performance accountabilities for disability issues on which DHBs are monitored;

appointments to the DHB Boards, to ensure the board has knowledge of disability issues where it is lacking;

the provision to set up additional advisory committees of DHB boards (e.g. a disability issues committee), to give disability issues a clear identity;

- i noted that the Minister for Disability Issues and the Minister of Health will write to the enhanced HHS boards to ensure that the boards' transition plans will include proposals for how they would address disability issues;

- j noted that the Ministry of Health (following consultation with other officials) has submitted a further report to the Minister for Disability Issues and Minister of Health on funding options for disability support services, which Ministers will submit to the Ad Hoc Ministerial Committee on Sector Change and then to SPH, to inform decisions on the division of planning and funding roles for disability support services;

RESIDUAL MINISTRY OF HEALTH SERVICE FUNDING AND ACCOUNTABILITY

- k noted that the Ministry of Health will be accountable for planning and funding a number of health and disability support services during the transition period, until responsibility for planning and funding all agreed health and disability support services is devolved to DHBs;

- l agreed that Ministry of Health spending on health and disability services will be funded through a separate output class in the Ministry's Estimates of Expenditure;

- m directed the Ministry of Health, the State Services Commission, and the Treasury to report back to the Ministers of Health and Finance and then to SPH on accountability arrangements for each health and disability support service to be funded directly by the Ministry of Health on an ongoing basis, with an initial report back by the end of November 2000, to ensure that:

there is a clear definition of the health and disability support service to be directly funded;

non financial and financial monitoring arrangements are sufficient for the purposes of service delivery and financial control;

conflicts of interests between the Ministry's planning, policy, funding and monitoring roles and dilution of DHB accountabilities are minimised;

- n agreed that, to facilitate standardised contracts and reduce transaction costs on all parties, the new legislation incorporate the ability of DHBs and the Ministry of Health to issue notices with the terms and conditions for payment of providers (currently referred to as "section 51 notices");
- o agreed that the New Zealand Public Health and Disability Services Bill provide for the Ministry of Health to contract for health and disability services with non-DHBs on behalf of the Minister of Health;

PRINCIPLES

- p agreed that:

initially DHBs will be subject to strong central control - they may be responsible for only a limited range of services with the balance being funded directly by the Ministry of Health;

additional responsibilities will transfer to DHBs as and when they have clearly demonstrated that they are capable of dealing with them;

if a DHB's performance is not good enough, it will not be allowed to expand its responsibilities, and if performance deteriorates the Government will be able to withdraw functions from DHBs and return them to the Ministry of Health;

responsibility for funding some tertiary and quaternary hospital services, some disability support services, and some public health programmes and services delivered by national organisations will remain at the national level indefinitely;

- q i noted that the Minister of Health expected a report from her officials on public health programmes by November 2000;

invited the Minister of Health to bring that report to SPH as soon as possible;

- r agreed that, as a principle, all funding for health and disability support services (and subsequent reports on expenditure) be indicated to DHBs before allocation to any regional or national budget;

- s agreed that DHBs be responsible for managing the financial risks of all services for which they are responsible (including costly and unpredictable services) in accordance with requirements set out in their funding agreements regarding 'operating environment policy' (which will also define specific circumstances in which risks would be managed by the Crown);

EXCEPTIONS IDENTIFIED TO DATE

- t noted that there will be specific exceptions to the general principle that DHBs will ultimately have responsibility for planning and funding all health and disability support services;
- u agreed that decisions on future arrangements for national screening programmes be made at a later date, when officials can ascertain how this will be managed within the DHB environment and when the results of the Gisborne Cervical Screening Inquiry are known;
- v agreed that, following a process of consultation with DHBs and forecasting by PHARMAC, the Ministry of Health will advise the Minister of Health on the 'notional' pharmaceutical budget requirement to which PHARMAC will work to manage the Pharmaceutical Schedule;
- w agreed that, in future, DHBs will be advised of the PHARMAC forecast of expenditure for their population, but that each DHB will be responsible for managing their pharmaceutical expenditure within the whole population-based funding budget allocated to them, and they will be charged for the actual pharmaceutical expenditure of their population;

CONSULTATION

- x directed the Ministry of Health to consult the Ministry of Pacific Island Affairs on future health reform papers.

REGULATORY IMPACT STATEMENT

Objective

1. The division of roles should contribute to the Government's objectives for the health and disability support sectors – improving the health and independence of the population, reducing disparities, and improving community participation in health and disability support – in the most effective and least-costly manner.

Statement of the problem and the need for action

2. Although DHBs will ultimately be responsible for planning and funding health and disability services, DHBs are unlikely to be able to do this individually for those health and disability support services which: span DHB districts; may be difficult for individual DHBs to manage financially; are developing; or which concern disability issues which are of a different nature.

Feasible options to achieve desired objectives

3. The paper takes each issue in turn and assesses the relative merits of:
 - i. collaborative DHB arrangements, with accountability arrangements and administrative and policy support from the Ministry of Health
 - ii. direct planning and funding of specific services by the Ministry of Health.
 - iii. separate local funding structures in the case of disability support.
4. The proposal is that DHBs should ultimately be responsible for the planning and funding of all health and disability support services, with the exception of those determined by the Government. The exceptions will be identified during the implementation phase in a report-back in November to the Ministers of Health and Finance.

Non-regulatory measures

5. The division of roles, and the extent and timing of devolution, can be largely managed within legislative provisions already decided on.

Regulatory measures

6. The proposals include provision in the New Zealand Health and Disability Bill
 - i. for the Ministry of Health to contract for health and disability services with non-DHBs, on behalf of the Minister of Health to facilitate standardised contracts and reduce transaction costs on all parties
 - ii. the ability of DHBs and Ministry of Health to issue notices with the terms and conditions for payment of providers.

Statement of the net benefits of the proposals

7. The exact net benefits of the proposals will not become known until Government has decided on the exact planning and funding arrangements for the types of services that are considered in this paper.
8. The arrangements are designed to improve co-ordination in planning and funding and minimise administrative costs, keeping DHBs accountable for funding the best mix of health and disability support services for their populations, within budget, and giving local users and communities a greater say over health and disability support services.

Consultation

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