# Section B: Settings / Ngā whakaritenga o te pūnaha

# 4 Governance and funding / Te mana tautiaki me te whāngai pūtea

*The current health and disability system is complicated and for many, confusing. There are multiple layers, overlapping mandates, and as a result unclear accountabilities. This section aims to make sense of current governance arrangements, consider what submitters and others within the system believe is working or not, and suggest key changes to clarify decision making rights, improve accountability and ensure communities are able to engage effectively in both planning and decision making.*

*No system can operate effectively without adequate funding and the current system has experienced a sustained period of little real growth which has added to the stress within the system. On the other hand, increasing funding alone will not guarantee equitable outcomes. This section looks at the big picture questions regarding what money is currently spent on, does that spending pattern explain the inequitable outcomes, and DHB deficits.*

Engagement undertaken during Phase One of the Review has stressed the importance of the following areas of governance:

- quality of the leadership at all levels
- cohesiveness of the system and a culture that is driven by consistent values and behaviours
- clarity of mandates, decision making and accountability
- improved intersectoral collaboration
- improved responsiveness to local communities
- improved responsiveness to iwi, Māori

During Phase One of the Review, we have not focused on the level of funding, or the details of particular funding mechanisms. We are focussed first on identifying how the system needs to change to achieve better health equity. Only once we are clear on how the system should operate can we ensure the funding mechanisms are right.

We have also heard concerns about funding in particular areas of the system. These include cost pressures in disability support services, the Waitangi Tribunal's findings on primary care funding, and contracting practices that impose costs on small non-government providers. These issues are discussed principally in the Service Section.

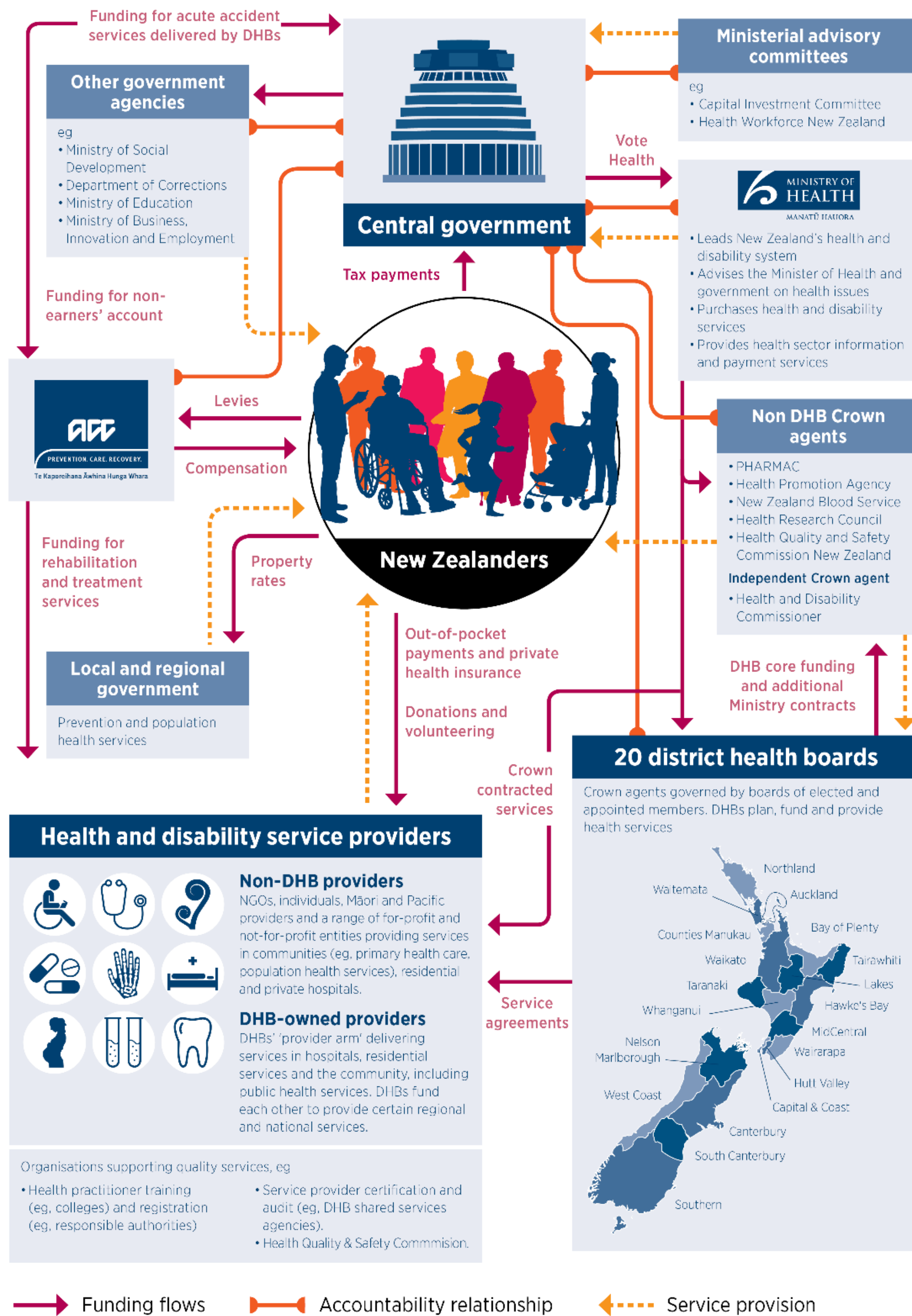
## Overview of current system arrangements

The New Zealand health and disability system is often described as a mixed system due to services being provided by a mix of public and private entities (both for-profit and not-for-profit). It is a major contributor to New Zealand's economy, accounting for around 9% of GDP and as a sector is the largest employer.

The structure of the health and disability system is illustrated in Figure 4.1. Key players in the system are the Ministry of Health, Crown entities, including district health boards (DHBs), primary health organisations (PHOs), non-government organisations (NGOs), public health units, local authorities, responsible authorities, and other government agencies.

The system's statutory framework consists of over 25 pieces of legislation and several international conventions (see Appendix E online). The most significant Acts are the New Zealand Public Health and Disability Act 2000, Health Act 1956, Accident Compensation Act 2001, Crown Entities Act 2004, and Public Finance Act 1989. Together, these Acts set the limits within which the system can practice.

**FIGURE 4.1: OVERVIEW OF THE HEALTH AND DISABILITY SYSTEM, AS AT JULY 2019**




**SOURCE: MINISTRY OF HEALTH.**

## KEY SYSTEM AGENCIES AND ORGANISATIONS

### MINISTRY OF HEALTH

*The Ministry leads the health and disability system and has overall responsibility for its management and development. It advises the Minister of Health and government on health and disability issues, directly purchases a variety of health and disability support services, monitors district health boards (DHBs) and other Crown entities, and provides health and disability sector information and payment services.*

### DISTRICT HEALTH BOARDS (DHBS)

*Twenty DHBs are responsible for providing and funding health and disability services in their districts. DHBs directly provide hospital services as well as some community and public health services, and contract with non-government providers for primary care, community, disability, and other services. DHBs make decisions on the mix, level, and quality of health and disability services within parameters set nationally. DHBs also jointly plan some services at a regional level.*

### PRIMARY HEALTH ORGANISATIONS (PHOS)

*Primary healthcare is funded through 30 primary health organisations (PHOs). DHBs fund PHOs to ensure the provision of essential primary healthcare services to people enrolled with a PHO through general practitioners. A PHO can provide primary health care services directly or through its provider members. The PHO Services Agreement is a contract between DHBs and PHOs for nationally defined services.*

### DISTRICT ALLIANCES

*District alliances are local leadership teams which work to support system integration and service planning. They have been a mandatory requirement through the PHO Service Agreement since 2013. They aim to promote integration and improve patient outcomes through DHB and PHO partnerships.*

### HEALTH CROWN ENTITIES

*Other significant entities include the Health Promotion Agency, Health Quality and Safety Commission, Health Research Council of New Zealand, New Zealand Blood Service, Pharmaceutical Management Agency (PHARMAC), Health and Disability Commissioner (independent), and NZ Health Partnerships (Crown-owned company).*

### NON-GOVERNMENT ORGANISATIONS

*The Ministry of Health and DHBs fund non-government organisations (NGOs) to provide services to consumers at a community level. NGOs include a wide variety of organisations providing services such as public health, primary health care, mental health, rehabilitation and detox, and disability support services.*

#### OFFICE FOR DISABILITY ISSUES

*The Office for Disability Issues serves as the focal point within government for disability issues and, as part of its core functions, helps to facilitate an effective working relationship between the disability sector and government agencies. The Health and Disability Commissioner promotes and protects the rights of consumers as set out in the Code of Health and Disability Services Consumers' Rights. This includes resolving complaints in a fair, timely, and effective way.*

#### PUBLIC HEALTH UNITS

*Thirteen DHB-owned public health units deliver public health services through contracts with the Ministry of Health. Public health units focus on environmental health, communicable disease control, tobacco and alcohol control, health promotion programmes, health status assessment and surveillance, and public health capacity development.*

#### LOCAL AUTHORITIES

*Local authorities increasingly deliver initiatives that promote community wellbeing. These initiatives vary between regional councils and territorial authorities and depend on council resources and priorities. Core activities that promote public health include resource management and the provision of drainage, sewerage, drinking water, recreation facilities and areas, and refuse collection. The Local Government Act 2002 was amended in 2019 and now requires local authorities to "play a broad role in promoting the social, economic, environmental and cultural well-being of their communities, taking a sustainable development approach" (section 3(d)).*

#### RESPONSIBLE AUTHORITIES

*The Health Practitioners Competence Assurance Act 2003 covers 16 health professional authorities that define scopes of practice for their professions and the qualifications necessary, register practitioners, and issue annual practising certificates. They also set standards of competence. Authorities are funded through professional levies.*

#### OTHER GOVERNMENT AGENCIES

*Other agencies fund, purchase, subsidise, or provide health and disability services that contribute to health and wellbeing through determinants of health. This includes intersectoral initiatives. Key agencies include the Accident Compensation Corporation, New Zealand Police, Sport New Zealand, Department of Corrections, Oranga Tamariki, Ministry of Social Development, Ministry of Education, Ministry of Business, Innovation and Employment, and Ministry of Justice.*

#### ACCIDENT COMPENSATION COMMISSION

*The commission manages the no-fault accident compensation scheme that covers injuries and accidents (commonly referred to as 'ACC'). Cover includes payment towards treatment, help at home and work, and help with income.*

# Roles and relationships

## Working effectively within an inherently complex system

New Zealand's health and disability system, like that of any other country, is inherently complex and will always be so given the breadth of services being delivered, the multiplicity of organisations involved, and the number of people being served.

However, we heard from organisations, providers and consumers that the system is more muddled and confusing than it needs to be. Management theory talks of healthcare systems as being 'complex adaptive systems', recognising that the impact of any single change or movement in one part of the system is unlikely to be linear or predictable on another part. International literature suggests that the most effective complex adaptive systems share two characteristics:

- a clearly defined purpose with effective feedback loops, which make the systems highly adaptable[118]
- distributed leadership that passes control from one to many. This is generally more effective than traditional, hierarchical ways of operating; 'command and control' systems seldom work in these systems.

Neither of these characteristics are very evident in the New Zealand system.

## Restructuring is disruptive – changing how we work in current structures could improve performance

Since its establishment, the New Zealand health and disability system has been through a variety of significant structural changes (summarised in Table 4.1). Like many health systems, rather than being purposefully designed, it has evolved in response to new health challenges, growing population demands, and political and professional drivers.

Policy researchers have commented that this system evolution results in systems with boundaries based on professional preferences, with frameworks retrospectively applied and processes developed to meet the requirements of service providers rather than the people they serve. One view is that this is exacerbated by a disproportionate focus on reform of the structural components as a solution to pressures.[119]

In discussions at stakeholder workshops, some held a view that the existing core structure of the system is fit for purpose but the way we work within it is flawed. These stakeholders said that legislation sets out a valid and appropriate role for DHBs but problems, such as how we approach implementation of policy change, lead to poorer outcomes than could have been achieved. People observed that an initial response to pressures on the system seems to be a jump to further structural change or to set up another institution. However, this response may not always address the root cause of the problems and may create further silos and confusion around accountabilities.

> *Substantial structural changes … have resulted in significant disruption and caused the sector to stand still for at least two years. (Group submission)*

**TABLE 4.1: HISTORY OF RESTRUCTURING IN THE NEW ZEALAND HEALTH AND DISABILITY SYSTEM**

| Period and legislation | Description |
|---|---|
| **1938–1983**<br>Social Security Act 1938 (replaced by the Social Security Act 1964) and Disabled Persons Community Welfare Act 1975 | The health system developed as a dual system of public and private provision. Disability support straddled the health (hospital based) and welfare (community based) systems.<br>In 1974, the Accident Compensation Corporation was established as a Crown entity, responsible for delivering New Zealand's accident compensation scheme, which seeks to minimise both the overall incidence and impact of injury. |
| **1983–1992**<br>Area Health Boards Act 1983 | Fourteen area health boards funded by a population-based formula were gradually established.<br>This was a period of deinstitutionalisation as hospitals providing long-term care for people with mental illnesses and disabilities were replaced by community services. |
| **1993–1997**<br>Health and Disability Services Act 1993 | Four regional health authorities were established. Purchasing and provision of health services were separated. Area health boards were reconfigured into 23 Crown health enterprises structured as for-profit organisations and subject to ordinary company law. Disability support services funding was transferred from the Department of Social Welfare to the regional health authorities. Public health services were unbundled and a separate public health purchasing agency, the Public Health Commission, was established. Māori Co-Purchasing Agencies were established in the Northern region. Purposeful approach to Māori providers being established and funded. |
| **1997–2000**<br>Health and Disability Services Amendment Act 1998 | In 1998, four regional health authorities were combined into one national purchasing agency, the Health Funding Authority. The 23 Crown health enterprises were reconfigured as 24 not-for-profit Crown-owned companies and renamed Hospital and Health Services. Regional health authorities continued to invest in and grow Māori providers and to contract for a wide range of Māori health and disability services. This period saw significant growth in the number of Māori providers. The Māori Provider Development Scheme, managed by the Ministry of Health, was initiated in 1997. |
| **2000-current**<br>New Zealand Public Health and Disability Act 2000 | In 2000, the first New Zealand Health Strategy was developed and further health system reform was initiated. In 2001, 21 (now 20) district health boards (DHBs) were formed with dual purchasing and provisioning responsibilities.<br>Purchasing functions of the Health Funding Authority were devolved to DHBs except for the purchasing of public health services, "national services", and disability support for people aged under 65.<br>The Ministry of Health led development of the first New Zealand Disability Strategy, and the following year leadership responsibility transferred to the newly established Office for Disability Issues.<br>Primary health organisations were established early 2000s to coordinate primary care services for their enrolled population.<br>The last Māori Co-Purchasing Agency was disestablished in 2010. |

**SOURCE: ADAPTED FROM PARLIAMENTARY SERVICES. 2009. *NEW ZEALAND HEALTH SYSTEM REFORMS* (RESEARCH PAPER 09/03).**

Our analysis of international jurisdictions suggests there is no 'one-size-fits-all' solution in terms of how best to organise systems to improve health outcomes and equity. Factors such as the way responsibilities are distributed can produce different incentives and impact on working practices and outcomes. Equal consideration must also be given to the social environment within which the system operates, the system's workforce, and the populations it serves.

## Values-driven leadership is critical

In 2010, the World Health Organization commissioned a set of guiding principles for strengthening health systems that would support improvement of global health outcomes.[120] It identified the need for strong, transformational leadership as a fundamental requirement. Many stakeholders echoed this requirement in discussions and submissions as a key contributor to the future success of the New Zealand system.

A culture that embraces effective leadership requires enough appropriately skilled people at all levels to lead and innovate.[121] Values-driven leadership implies a conscious commitment by leaders at all levels to lead with organisational values and create a culture that improves performance, accountability, provision of services, and outcomes. Work undertaken during Phase One of the Review has clearly demonstrated that the key determining factors in what distinguishes a successful system from a dysfunctional one are the:

- quality of the leadership at all levels
- cohesiveness of the culture that drives the behaviours throughout the organisation.

We observed many examples of great leadership and culture-driven behaviour, both in New Zealand and internationally, but the variability around the country or even within a DHB is immense. We also recognise that in a country of almost 5 million people the pool of people with high-level leadership skills is limited. This means, first, we must design a system appropriate for a small country and, secondly, we must take steps to increase the leadership capability within that system.

## Lack of common purpose despite unifying strategies

Strategies have been developed over time to provide guidance and direction for the system (Figure 4.2).

FIGURE 4.2: TIMELINE OF HEALTH AND DISABILITY STRATEGIES SINCE 2000 (NEW ZEALAND)

The overarching strategy for health in New Zealand, the New Zealand Health Strategy,[122] was refreshed in 2016 after extensive consultation and involvement of sector leaders, independent experts, and researchers. It sets out the high-level direction for the health system from 2016 to 2026, identifying five strategic themes that would move the system toward that future. The vision articulated in that strategy reflects the Review's task of delivering a system that delivers hauora, wellbeing, and equity of outcomes for all New Zealanders.

> *All New Zealanders have the right to a system that enables everyone to live well, stay well, and get well.*

Our Phase One discussions have confirmed this strategy is generally widely supported, although it is also recognised that it lacks adequate recognition of Tiriti/Treaty related issues. However, fragmentation in the way organisations within the system work leads to disconnect between strategy and outcomes: the objectives are not owned and shared across the system. For many, there is little sense that everyone is working to a shared set of values and towards a common goal.

The system is also characterised by a range of organisational forms operating under different incentives, values, and drivers of behaviour. These include public service departments, Crown agents, not-for-profit entities, and private businesses. We recognise in this a significant difference in configuration to other largely public national systems, such as NHS in the United Kingdom. In our system, commercial entities play a significant role in the provision of health care across all tiers of services. This has its roots in debates around the introduction of the Social Security Act 1938 in which clinical professions held fast to their freedom to engage in both public and private practice. Clearly, different incentives and drivers of behaviour are at play.

## Need for common values and unifying principles

The Panel is firmly of the view that New Zealand needs to create a more cohesive health and disability system that is underpinned by a:

- common set of values that aligns workforce behaviour, culture, and cooperation in delivering exceptional patient and whānau-centred outcomes across all publicly funded services
- unifying set of principles that aligns the system toward a common set of objectives and shapes funding, governance, accountability, data, and service delivery within in the home, community, and hospital

Analysis of values in use across health and disability organisations in New Zealand has highlighted that, although commonalties exist, there is no core set of principles or values overarching the system. Wide variability also exists in terms of focus, tone, bilingual representation, and style. This includes lack of a consistent reference to te Tiriti o Waitangi /the Treaty of Waitangi (Figure 4.3).

A review was also undertaken of some international health systems. Four well respected but very different health organisations who deliver a core set of system-level principles and values that drives leadership, culture, and behaviour are noted (see Appendix F online).

**FIGURE 4.3: OVERVIEW OF VALUES IN USE ACROSS HEALTH AND DISABILITY ORGANISATIONS**

| PEOPLE CENTRED | WORKFORCE CENTRED | ACCOUNTABILITY AND QUALITY IMPROVEMENT |
|---|---|---|
| *the way we look after people under our care, patients, and whānau (compassion, empathy, professionalism, respect)* | *the way we look after each other and work together (partnership, respect, communication, supporting, collaboration)* | *the way we ensure continued improvement and quality of services (excellence, monitoring, being responsible, accountability, learning systems)* |

SOURCE: REVIEW ANALYSIS OF HEALTH AND DISABILITY ORGANISATIONS.

During Phase One we also engaged directly with stakeholders asking them What are the key values that you would want to underpin our future public health and disability system? Based on our engagement, values have been expressed in a variety of ways and can be grouped into seven themes.

- **Te Tiriti o Waitangi / the Treaty of Waitangi:** A system that embraces te Tiriti, including a commitment to rangatiratanga (authority, ownership, leadership) and mana motuhake (self-determination, autonomy). One that works to avoid institutional racism and build cultural leadership and governance across all aspects of the system.
- **Wellbeing, hauora (health and wellbeing), and prevention:** A system that empowers people to keep healthy and avoid, minimise, or delay poor health. One that embraces a holistic perspective – including wairuatanga (spirituality), relationships, belonging, and empowerment.
- **Upholding equity, aroha (love), manaakitanga (reciprocity and support), fairness, and respect:** A system that provides all New Zealanders with high-quality, culturally appropriate, affordable, and accessible services regardless of where you live and how you identify.

- **Trust:** A mana-enhancing system that builds trust within and across communities and organisations, treating people as partners in care and actively collaborating to enhance health and wellbeing. A system that builds and values intersectoral relationships.
- **Integrated, collaborative, and connected:** A system that is cohesive and well-coordinated, exemplified by high levels of collaboration within the entire system and intersectorally. A system that supports cooperation and transitions between services, with a workforce that works together to deliver seamless support to all.
- **Outstanding leadership, work practice, and whakawhanaungatanga (relationship building):** A system with a shared understanding of purpose and clarity of leadership that values its workforce and provides secure and supported workplaces cross the system.
- **Supporting excellence, integrity, and innovation:** An evidence-based system that makes best use of available resources for all New Zealanders and strives for quality of care in all it does. This includes using data effectively and ethically across the system, valuing expertise of communities in service delivery, and welcoming fresh thinking and innovation.

Submitters also referred to a common set of principles, including a system based on hauora, equity, human rights, universal health services regardless of pathway, strong leadership, a whole of system approach, and Tiriti/Treaty-based delivery of health and disability services. Those who identified as having a disability focused particularly on inclusion and participation.

# Decision making

## Inconsistency in decision making

In our discussions, people raised concern about how decisions are made within and across organisations in the sector. They commented that the current complex set of arrangements leads to a lack of clarity about how to influence change, resulting in delays and, sometimes, impasses that are hard to progress.

Previous reviews highlighted that decision making across DHBs is unduly messy. In 2009, the Ministerial Review Group found that the incentives for regional collaboration were not strong and parochial interests could prevent collective regional decision making from occurring. At that time, Treasury commented on “fragmented decision-making” in the sector and noted that “collaborative mechanisms and accountabilities are weak, and do not lead to rational and coherent service and capacity planning or efficient use of resources”.[123]

The changes proposed to strengthen regional decision making did not progress as anticipated. In 2015, the Capability and Capacity Review commented that that “DHBs [are] often operating in regional and financial isolation”, suggesting that a new system operating model needed to “[r]eject the approach that regional DHB silos are acceptable” and move towards a “cooperative and collaborative national approach of delivery of outcomes”.[124]

Increasingly in health systems in developed countries, jurisdictions have moved toward decentralised systems with a high degree of devolved and networked decision-making arrangements. The New Zealand Productivity Commission, in its work to support improved outcomes from social services, identified two system-level architectural designs that are characterised by their approach to distribution of decision

rights. These are 'top-down control' (where decision-making power sits primarily with the relevant minister or chief executive of a central government agency) and 'devolution' (where substantial decision-making powers and responsibilities are devolved to autonomous or semi-autonomous organisations with separate governance structures).[125]

In reality, our system includes a complex mix of different decision-making models, leading the Ministry of Health to characterise it as being 'semi-devolved'.[126] There is a mix of centrally prescribed direction (for example, regarding specification of the range of services required), that runs alongside a degree of devolved decision rights (with DHBs required to assess and meet local need) and many other examples of different arrangements in between.

> *The role of the [Ministry of Health] in providing the health system stewardship over the next five-ten years is critical to driving the change we require in health outcomes. The DHB model is well placed to respond to local needs. However, it currently occurs in a vacuum of poor strategic vision from the centre about how services should be organised nationally, regionally and, most importantly, sub regionally. (Group submission)*

From our discussions with stakeholders and analysis of the system, we have identified that there is still no coherent decision-making framework to guide the sector. There are no transparent, consistent principles to guide what decisions should be taken where within the system. It appears that existing collaborative efforts are mainly dependent on goodwill and personal relationships.

### Limited flexibility and autonomy for DHBs at a district level

Improving responsiveness to local populations was a key aim of the reforms in the early 2000s. At face value, the system created under the New Zealand Public Health and Disability Act 2000 appears to have a high degree of devolved decision rights.

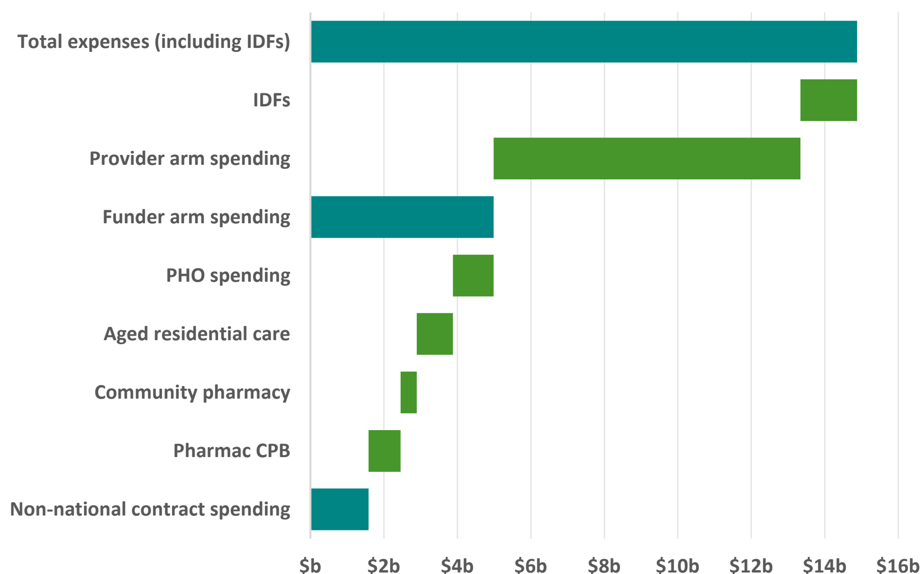
However, people have highlighted significant constraints on DHBs' flexibility to take strategic decisions so they can tailor responses to local need.

Commonly identified barriers include:

- the service coverage schedule (which specifies minimum requirements for access to a range of services and standards for safety and quality)
- nationally agreed contracts for devolved services (for example, such as the PHO Service Agreement)
- multi-employer collective agreements (negotiated between DHBs and employee unions) that specify terms and conditions for the majority of staff.

For example, nearly two-thirds of DHB spending with non-DHB providers is through nationally negotiated contracts. Around $2.5 billion of devolved DHB spending is allocated to national contracts for primary care, community pharmacy, and aged residential care. A further $871 million is controlled by the Pharmaceutical Management Agency (PHARMAC) to purchase pharmaceuticals.

FIGURE 4.4: ALLOCATION OF DHB FUNDING, 2017/18




Note: CPB = combined pharmaceutical budget; IDF = inter-district flow; PHARMAC - Pharmaceutical Management Agency; PHO = primary health organisation.

SOURCE: MINISTRY OF HEALTH, DHB FINANCIAL ACCOUNTS.

## National prioritisation overrides locally determined prioritisation

Research undertaken about how much autonomy DHBs have to steer the direction towards local priorities also concluded that "the priorities and requirements of central government and the weight of institutional history were found to be the most influential factors on DHB decision making and practice, with flexibility and innovation only exercised at the margins".[127]

However, against this, we recognise both the need for consistency in ensuring equitable access and the potential efficiencies from managing some DHB contract negotiations on a national basis. The system needs to balance how far the level of constraint imposed impacts on the ability of DHBs to deliver on their prescribed functions.

## Mandates are unclear and functions overlap across organisations

Many stakeholders have commented on the overlap in the functions of organisations and a lack of clarity on mandates, leading to duplication of effort, inefficiency, and reduced accountability for performance. Calls have been made to clarify roles and relationships between entities.

This lack of clarity was a key theme in the findings of the Ministerial Review Group in 2009, which led at the time to a conclusion that the sector was not well placed to meet current and forthcoming clinical and fiscal challenges. Treasury commented then on the "lack of clarity in the roles and functions, and relationships between, the organisations in the sector, including the Ministry, DHBs, and PHOs".[128] Sector feedback we received indicates this view remains current, as the following quote exemplifies:

> *The delineation between the commissioning functions of the Ministry of Health …, DHBs and PHOs is sometimes unclear. This can result in a lack of coordination of services, unplanned variation in the delivery of services, and ineffective use of funding resources. There is also a need for improved coordination with national bodies that have commissioning functions, such as the Accident Compensation Corporation … and the Ministry of Social Development … (Group submission)*

There are also numerous examples of where processes, or analysis, are being replicated in numerous boards when it could be argued that "doing it once" would be much more cost effective. While shared services agencies are assisting in reducing some of this duplication, we have observed many examples where costs might be reduced by more sharing of knowledge or expertise; or by combining to improve purchasing power in the market, especially as digital technologies become more pervasive.

> *We need to re-think our approach to procurement of digital resources, shifting from a local approach to a coherent national strategy and framework … There are significant opportunities for DHBs to coordinate their combined investment, to communicate their requirements and more effectively influence suppliers and markets.*
> *(Organisation submission)*

## Collaborative planning

### Long-term service planning framework

Service planning has been defined as the process of determining the health needs of a population and how those needs can be met through the effective allocation and deployment of existing and anticipated future resources.[129] It focuses on developing and implementing change in service design and configuration and happens within the broader context of planning that spans government policies, strategies, and formal accountability documents.

The starting point for planning should be understanding population health needs, assessing how well these needs are being met, and deciding priorities to drive towards the goal of equitable health and wellbeing outcomes for all New Zealanders. The current planning framework places little emphasis on a formal requirement to undertake health needs assessments or to develop medium-term strategic priorities at national, regional, or local levels. The system does not have a coherent service policy and planning framework or a national overview of the current configuration of publicly funded services.

Rather, the focus appears to be on specifying the requirements for the provision of particular services, which are then referenced throughout many planning and accountability documents. These documents include:

- nationally focused service strategies and action plans (for example, in relation to cancer and mental health services)
- the Operational Policy Framework
- the Nationwide Service Framework.

There was a consistent view that the short-term and fragmented nature of planning and the requirement for DHBs to meet zero or low deficits every year, negatively affects how the sector works. The approach to improving health outcomes and equity requires a long-term approach yet it sometimes appears that the system is run as a series of unconnected short-term projects that do not use standardised planning tools and methods.

### No mechanisms to enforce or hold DHBs accountable collectively for regional planning decisions

- As noted previously, the need to formalise and strengthen regional decision-making structures was a key theme from the 2009 Ministerial Review Group, including a recommendation that DHBs should collaborate to produce regional service plans and that DHB chairs and chief executives should have delegated authority to make decisions at the regional level. Any disputes would be escalated to a new entity, the National Health Board. These recommendations were not implemented.
- This theme was also prominent in the Long-Term Service Framework programme (established in the Ministry of Health) that called for the rebalance of some decisions towards regions.
- In 2010, legislation was changed to lay the foundation for increased levels of regional collaboration. Previously, the New Zealand Public Health and Disability Act 2000 had required individual DHBs to develop annual plans and three-yearly district strategic plans. The 2010 change set aside the requirement for district strategic plans (that included a requirement for consultation with the public) in favour of annual regional plans (set out in the New Zealand Public Health and Disability (Planning) Regulations 2011).
- These regulations require the regional plans to include a strategic element and an implementation element, set out expectations about the content for each element, and define the procedural elements for the development of these plans as being (under regulation 7):

  (1) A DHB that is involved in preparing a regional service plan must consult with the public in relation to the plan if the Minister considers that—

    (a) the plan proposes changes to services, including to service eligibility, access, or the way services are provided; and

    (b) the proposed changes will have a significant impact on recipients of services, their caregivers, or providers.

  (2) Before the Minister and the DHBs agree on the regional service plan, the chief executive and the chairperson of the board of each DHB that is to participate in the plan must agree to and sign the plan on behalf of the DHB.

  (3) The implementation element of a regional service plan must be reviewed annually.

  (4) Regional service plans must be updated annually.

In the system today, we see some regional collaboration across DHBs through development of regional services and plans and some commitment to the shared support agencies. We can also see examples in the sector of clinically driven regional initiatives.

However, while the legislation provides a clear indication that coordination is important, the overall accountability framework does not hold DHBs to account collectively for regional performance. DHB Boards are required to sign off the regional service plans, but individual DHBs still need full board sign off for collective spending decisions.

> *The individual financial and service accountability for each DHB means that the shared accountability for regional services is often unclear and competing imperatives around resources or service sustainability can get in the way of a broader agreement in the interest of a region. (Group submission)*

Our recent discussions with stakeholders suggest that the challenges highlighted in previous reviews of the system still exist. There have been calls for increased levels of coordination and accountability at a regional level.

> *It is entirely proper that there be district specific input into the running of local health services so the current structure will suffice but should be coordinated at regional level. (Individual submission)*

Currently, there are no standards or clear expectations against which to assess either a region's collective planning efforts or the contributions made by individual DHBs. Arrangements are still largely dependent on relationships and goodwill.

## Supporting better intersectoral collaboration

The World Health Organization emphasises the need for health agencies to engage with other sectors of government to improve health equity. It has provided evidence from a broad range of case studies in many countries and cultures, demonstrating the positive impact of intersectoral action and the importance that populations attach to such approaches.[130]

Stakeholders in New Zealand strongly endorsed the value of intersectoral approaches:

> *There are certain themes that emerge repeatedly during our discussions with our workforce, our population and our community. The social determinants are the biggest challenge; warm, dry, affordable and appropriate housing for our diverse populations (for example, housing that accommodates our Pacific households who do not configure easily into a two bedroom structure). Wages that reflect the realities and pressures of life in [New Zealand], access to transport, nutritious food, and more subsidisation of healthcare in areas that hit diverse populations hardest, such as dental care and pharmaceuticals. We need better intersectoral collaboration. If we want to address the social determinants of health, then the decision makers from the agencies that can affect change in these areas need to be in communication and designing solutions, with the community that achieve the community's outcomes. (Organisation submission)*

However, stakeholders have commented that while a willingness to engage and work across sectors exists, the time and energy to do so must be balanced against a vast array of competing demands.

There are many New Zealand examples of where cross-sector collaboration has had positive impacts for communities. Whāngaia Ngā Pā Harakeke coordinates help from across sectors for people, including children, involved in police family violence callouts. Housing First gives homeless people with mental health and addiction needs a home with secure tenancy and supports to remain in that home, regardless of problems. Mana Whaikaha connectors are working with disabled people, employers, education providers, and community groups to build opportunities for disabled people to gain skills and get into sustainable jobs.

#### EXAMPLES OF SUCCESSFUL CROSS-SECTOR INITIATIVES

***Healthy Families Lower Hutt***

*The cross-sector initiative Healthy Families Lower Hutt, led by Hutt City Council, involves representatives from local iwi, the district health board, primary health organisations, the education sector, a sports trust, and the Ministry of Health, along with private sector representation from a New World owner and Catalyst Pacific Ltd.*

*A collaborative work programme created four examples of local systems change.*

- ***Healthy Active Streets and Spaces –*** *leading development of the Streets Alive framework, which will provide practical guidance and measurable indicators to inform design decisions for streets and public spaces.*
- ***Active Transport*** *– working closely with the community and council planners to encourage active transport, creating connections to local and city destinations.*
- ***Increasing Access to Water*** *– reorienting funding towards water fountains and enabling pro-water and water-only places where people live, learn, work, and play (such as in schools), reaching close to 4,000 students, sports clubs, and community facilities.*
- ***Player of the Day*** *– design of an alternative approach to break the association of food sponsorship of junior sport. For sports organisations that demonstrate a pro-water kaupapa (strategy, theme), player of the day certificates include free swimming pool passes. (Hutt Valley DHB provided this example.)*

***SmartStart***

*An online service for expectant and new parents. It provides a single source of information on having a baby from a variety of different agencies (including from the health and disability sector, the Ministry of Social Development, and Inland Revenue) to reduce the burden on new parents interacting with government. (The Government Chief Digital Officer provided this example.)*

# Representation and engagement

## Community ownership and engagement

Meaningful and respectful partnership and engagement enables the aspirations, values, and needs of communities, consumers, and whānau to be reflected in the delivery of health and disability services, policies, and other decisions.

Key engagement mechanisms deployed by DHBs and other parts of the system include:

- having community representation on DHB boards, including Māori representation proportional to population
- establishing advisory councils and committees, including consumer councils involved in how health and disability services are delivered within and across communities
- holding board and other meetings that are open to the public
- establishing other engagement groups
- managing active engagement programmes within community settings, for example to consulting on specific initiatives.
- collecting and reporting patient feedback to the health-care system, usually through patient surveys; for example, the Health Quality and Safety Commission routinely measures patient experience for adult inpatients and in primary healthcare settings
- working with advocacy and patient-affiliated groups, such as the Cancer Society and other NGOs, that may also be contracted to provide services and advice.

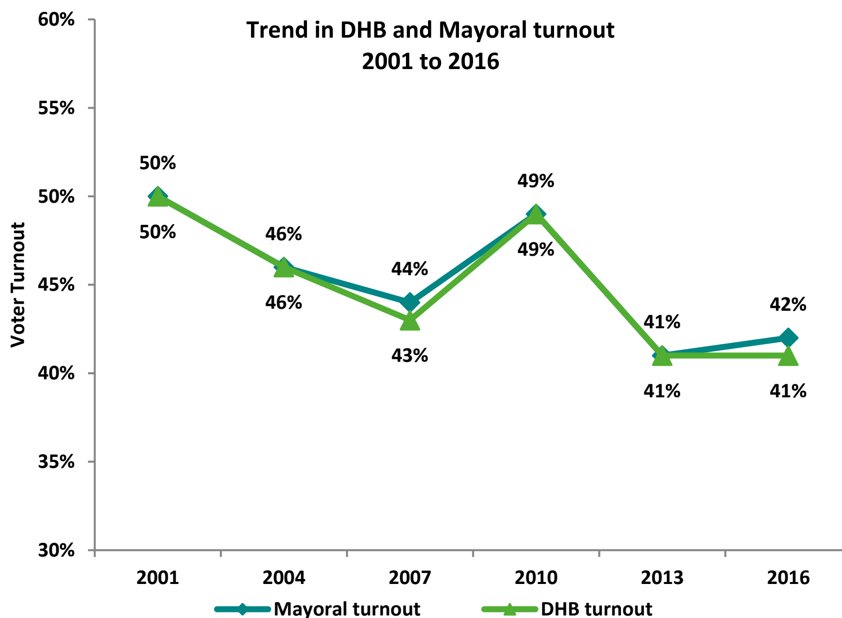
Institutions also play a key role, including the Office for Disability Issues, serving as the focal point within government on disability issues and, as part of its core functions, helps to facilitate an effective working relationship between the disability sector and government agencies.

While the importance of consumer involvement in shaping health care is widely acknowledged and supported, evidence of the effectiveness of specific mechanisms is limited.[131] For example, one of the primary ways consumers have been involved is by acting as representatives on advisory councils and committees, bringing with them the unique first-hand knowledge acquired through their experience of being active users of the system and providing insights that might otherwise be overlooked.[132] However, research argues that some individuals may find it difficult to participate actively in conversations with ‘professionals’. Further, the ‘representatives’ may not accurately represent the views of an entire cohort of consumers, which may limit the range of interests and diversity of experiences being represented for consideration in the decision-making process.[133]

## Impact of elected DHB board members

The election of DHB board members is seen as a critical means of ensuring community engagement. DHB boards comprise seven members elected by the community every three years (concurrently with local government elections) and up to four members appointed by the Minister of Health. The Minister of Health appoints the chair and the deputy chair of each board from among elected and appointed members. Under the legislation, the Minister must endeavour to ensure that Māori membership on the board is proportional to the number of Māori in the DHB’s resident population and that the board has at least two Māori members.

FIGURE 4.5: DHB BOARD AND MAYORAL ELECTION TURN-OUTS, 2001–2016




SOURCE: DEPARTMENT OF INTERNAL AFFAIRS.

Analysis of DHB board elections shows that voter turn-out closely tracks overall local government patterns (using mayoral turnout as a summary measure across all council types) (see Figure 4.5). It shows that voter turn-out was highest at 50% in the first DHB election in 2001 and has fallen to 41% in the most recent elections. Less than half the eligible population is, therefore, participating in the election process, and, for many voters, their knowledge of candidates is limited.

Stakeholders hold diverse views about majority-elected DHB boards being an effective means of community representation. Some argue that locally elected DHB members bring a useful tension to the system, encouraging DHBs to innovate in the provision of tailored local responses to national policy directions. Others argue that the elected members can be more focused on community issues.

Measuring the effectiveness of the governance provided by boards is difficult, but the Review observed a wide variance in both the range of experience represented within boards and the quality of advice provided to board members to support decision making. There is also little systematic ongoing training available to board members wishing to increase their skill levels.

Research about the benefits and costs of election of board members is limited (see Table 4.2), and the findings are mixed.[134]

**TABLE 4.2: BENEFITS AND COSTS OF ELECTED DHB BOARD MEMBERS**

| Benefits | Costs |
| --- | --- |
| ▸ Tighter local accountability for local decision makers | ▸ Expenditure on the election process |
| ▸ Broader representation of the local community on the boards | ▸ Unrepresentative interests winning power in low-turnout elections |
| ▸ Decisions reflecting the salience of local issues and reinvigorated public engagement | ▸ Conversion of boards into political arenas |

One research project looking at the New Zealand system found that the combination of elected members and public board meetings prompted a cultural change toward openness. However, where community engagement had improved, there was no evidence that this was a direct result of the presence of elected members.[135] In 2010, Robin Gauld concluded similarly that the New Zealand experience indicates that "that electoral mechanisms may play only a limited role in promoting participation and could possibly counter public involvement … an elected board may be but one of multiple, parallel methods for public participation".[136]

## Māori representation on DHB boards

Māori representation on DHB boards is a legislative requirement. As noted, the Minister of Health must try to ensure Māori membership of the board is proportional to the number of Māori in the DHB's resident population and that there are at least two Māori members.

Table 4.3 summarises available data relating to Māori representation on DHB boards since 2001 when they were first established. The table shows the following.

- The proportion of Māori representatives across all board members remained reasonably stable at around 21%. (As a comparator, in the 2013 census, almost 15% of those who reported an ethnicity identified as being Māori.[137])
- An average of two DHBs each year have had fewer than two Māori board members. During 2018, this dropped to only one DHB (Hutt Valley, where a Māori board member had resigned).
- An average of around 27% of DHBs had a lower proportion of Māori elected onto their board than across their whole population. In 2018, this had increased to 35% (seven DHBs).
- Close to five DHBs per year have had more than two Māori board members.
- Around 15% of DHBs have had a Māori chair or deputy.

**TABLE 4.3: MĀORI REPRESENTATION ON DHB BOARDS, AVAILABLE DATA FROM SELECTED YEARS 2001–2018**

| | 2001 | 2004 | 2007 | 2010 | 2013 | 2016 | 2018 |
|---|---|---|---|---|---|---|---|
| DHBs with fewer than two Māori board members | 0 | 1 | 5 | 2 | 5 | 0 | 1 |
| DHBs with lower proportion of Māori on board than in population | 4 | 5 | 5 | 4 | 8 | 6 | 7 |
| DHBs with more than two Māori board members | 4 | 3 | 6 | 5 | 5 | 5 | 5 |
| DHBs with Māori chair or deputy | 5 | 4 | 4 | 1 | 1 | 3 | 3 |
| Total number of Māori board members across all DHBs | 50 | 51 | 47 | 44 | 40 | 45 | 46 |
| Percentage Māori board members across all DHBs | 22% | 22% | 20% | 20% | 18% | 22% | 22% |
| Total number of board members across all DHBs | **231** | **231** | **231** | **220** | **220** | **209** | **208** |

Note: Southern DHB has been under the control of a Commissioner (under section 31 of the New Zealand Public Health and Disability Act 2000) since June 2015.

SOURCE: DATA SUBMITTED BY THE MINISTRY OF HEALTH TO THE WAITANGI TRIBUNAL (WAI 2575).

Clearly, Māori representation on boards is only one level of Māori participation in health sector governance.

## Developing Māori representation across the sector at the governance level and shared decision making with the Crown

The NZ Public Health and Disability Act 2000 specifies te Tiriti o Waitangi/ the Treaty of Waitangi obligations of DHBs, which includes, but is not limited to, ensuring and providing relevant information on meeting the DHBs obligations to:

- establish and maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
- foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori through building the capability of all DHB staff in Māori cultural competency and te Tiriti o Waitangi/The Treaty of Waitangi.

The Ministry of Health requires all DHBs to report on how they are meeting these obligations as part of their annual planning process. Most Boards have some type of 'partnership board' arrangement in place between the DHB and manawhenua (local iwi groups). While the form and role of these groups differ across DHBs, commonly their main focus is on improving local and regional Māori health outcomes.

Functions of these partnership agreements vary but examples include: Māori needs assessment and strategic planning; developing cultural competency and Tiriti / Treaty understanding of the health workforce and recruitment and retention strategies for Māori staff; incorporating tikanga and Māori knowledge into service planning and delivery; and engagement in decision making, and accountability monitoring.

However, it was acknowledged by the Crown and witnesses at Wai 2575[138] that these partnership boards were regionally variable, were not always involved in decision making at the governance level, had less 'mana' than a statutory board, and had become a '*tokenistic*' '*tick box*' for DHBs. Further, a number of those on the partnership boards lacked the capacity and capability to contribute effectively, and as iwi/hapū representatives on a number of boards were not always able to regularly attend meetings.

Stakeholders raised several significant issues focused on the need to improve and develop Māori participation and representation across the sector at the governance level and to redistribute decision-making power in relation to funding and contracting arrangements.

Specific themes include:

- a perceived lack of support for Māori (and Pacific) leadership development
- a lack of focus on and investment in local leadership to deliver on local priorities
- the need for developing stronger iwi partnerships with DHBs
- a lack of Māori-specific policy development and implementation
- decision-making models (and funding arrangements) constraining local health providers from taking innovative approaches to local health issues and insufficient investment in preventive care approaches
- contract-driven decision making, including a distribution of resources and power in the system that constrains decisions and choices.

> *The best health and disability system for New Zealand in 2030 is one that has been designed with Iwi and Māori, and as such, will have seen a drastic reduction in health disparity. The holistic approach and world view of Māori will be at the heart of investment, planning, design and delivery. We say this with the conviction that what works for Māori will work for all New Zealanders. (Organisation submission)*

# Accountability and performance

## Accountability and reporting requirements are labour intensive

Current extensive accountability mechanisms for DHBs are set out in Table 4.4. Reporting requirements relating to financial and other performance against specific measures (such as health targets) are covered later in this section.

**TABLE 4.4: ACCOUNTABILITY MECHANISMS**

| Category | Mechanisms |
|---|---|
| **Government expectations**<br>These documents set out the policies of the government of the day and the role DHBs are expected to play in implementing those policies. | ▸ **Annual letter of expectations** – sets out the strategic priorities of the government for the health and disability system.<br>▸ **Enduring letter of expectations** – is issued periodically by the Minister of Finance and Minister of State Services to all Crown entities (including DHBs) to provide a more general set of expectations, including, for example, the need to achieve value for money and strong entity performance. |
| **Planning documents**<br>These documents set out the short-term course DHBs intend to follow to best meet the health needs of their populations. | ▸ **Annual plan** – sets out how a DHB delivers health services locally to meet government priorities, with a focus on health equity, and how this can be provided in a financially responsible manner and in line with the DHB's role and functions. Māori health plans are incorporated into the annual plans.<br>▸ **Regional service plan** – identifies shared goals for a region and sets out how these will be achieved. |
| **Accountability documents**<br>These documents allow Parliament and the public to measure the performance of DHBs and to hold them accountable. | ▸ **Statement of intent** – is required every three years to set out the high-level objectives and strategic focus for the current and next three years.<br>▸ **Statement of performance expectations** – is a component of the annual plan, provides forecast financial statements for the current year.<br>▸ **Crown funding agreement** – sets out the agreement (including accountability requirements) between the Minister and DHBs on the public funding the DHB will receive in return for providing services to its resident population.<br>▸ **Operational policy framework** – is a set of business rules, policies, and principles for the operating functions of DHBs.<br>▸ **Service coverage schedule** – sets out the national minimums for the range and nature of health services to be funded by DHBs. For some services, the schedule also covers subsidies and user charges as well as specific quality and audit requirements.<br>▸ **Annual report** – reports on DHB performance for the year against the measures set out in the DHB's statement of performance expectations and their current statement of intent.<br>▸ **Quality accounts** – is a means by which healthcare providers account annually for the quality of the services they deliver, just as financial accounts show how an organisation uses its money. |

DHB stakeholders commented that accountability mechanisms and associated reporting requirements are resource intensive. They also highlighted the tendency of the centre to add priorities to an ever-expanding list of demands (see Table 4.5 as an example), rather than reassessing and removing items from the list:

**TABLE 4.5: GOVERNMENT'S ANNUAL PLANNING PRIORITIES FOR HEALTH 2017/18**

*As an example, see the Government's Annual Planning Priorities for 2017/18. The priorities seem to be … everything. (Organisation submission)*

- Better Help for Smokers to Quit
- Bowel Screening
- Child Health
- Childhood Obesity Plan
- Disability Support Services
- Faster Cancer Treatment
- Healthy Ageing
- Healthy Mums and Babies
- Improved Access to Elective Surgery
- Improving Quality
- Increased Immunisation
- Keeping Kids Healthy
- Living Well with Diabetes
- Living Within our Means
- Mental Health
- Pharmacy Action Plan
- Primary Care Integration
- Prime Minister's Youth Mental Health Project
- Raising Healthy Kids
- Reducing Unintended Teenage Pregnancy
- Shorter Stays in Emergency Departments
- Supporting Vulnerable Children

## Issues relating to measurement of system performance

The Ministry of Health is responsible for monitoring system performance and provides reports to the Minister of Health (and, in some cases, the Minister of Finance) each month. Over and above the accountability mechanisms and associated reporting outlined above, DHBs must complete a variety of financial and non-financial performance reporting (Table 4.6).

TABLE 4.6: FINANCIAL AND NON-FINANCIAL PERFORMANCE REPORTING BY DHBS

| Type | Mechanism |
|---|---|
| **Financial performance** | ▸ **DHB monthly financial report** – Each DHB provides templated financial data to the Ministry the end of each month.<br>▸ **DHB sector financial report** – The Ministry of Health completes a monthly sector wide report, provided to ministers each month and, in due course, these are published on the Ministry's website. The report summarises the DHBs' financial performance (for example, operating results and capital expenditure) for the year to date based on data and comments provided by DHBs in their monthly financial reports. It includes reports on the Ministry's interactions with the sector and highlights where the sector or an individual DHB reports a significant variance against financial budgets set in the DHB's annual plan. There is also commentary on sector-wide issues with financial implications. |
| **Non-financial performance** | Additional mechanisms for monitoring non-financial performance of DHBs include:<br>▸ **Health targets** – a set of national performance measures designed to improve the performance of health services that reflect significant public and government priorities. The Ministry of Health is developing a new set of performance measures, with a focus on population health outcomes.<br>▸ **DHB quarterly summaries** – spreadsheet files reporting each DHB's performance against each of the health targets as a percentage are published quarterly on the Ministry's website.<br>▸ **PHO quarterly summaries** – a dashboard summary (referred to as the 'PHO league table' of each PHO's performance against two of the health targets (Increased Immunisation and Better Help for Smokers to Quit) is published quarterly on the Ministry's website.<br>▸ **Elective Services Patient Flow Indicators** – a measure of whether DHBs are meeting the required performance standard at various points in the patient journey towards provision of elective surgery. These indicators are published by DHB and collated on a national basis, including standardised values that allows comparison of DHB results irrespective of their size. |

Stakeholders, particularly those from DHBs and PHOs, have raised concerns about measurement of system performance, saying no common view exists about what 'good performance' or success for the system would look like. As a result, financial performance (with a focus on DHB deficits) becomes the key driver – there is no sense of seeking a balanced view across other dimensions of performance.

> *It is important at a national level that consistent aggregated measures exist across DHBs to enable the health system to understand performance, opportunities for improvement and to articulate an authoritative performance narrative to central agencies and wider stakeholders. (Organisation submission)*

The Health Quality and Safety Commission also plays an active role in monitoring and improving performance. The Commission's Atlas of Healthcare Variation is a well-developed tool that shows variation in health services and outcomes by DHB. The Commission's role is to work with the sector to improve performance and reduce unwarranted variation in patterns of care, but it does not have a mandate to hold an organisation to account for addressing such variation.

In addition to the performance management mechanisms outlined above, the Ministry of Health also runs a system quality improvement programme. The System-Level Measures (SLMs) framework aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community, and hospital) using specific quality improvement measures. It provides a foundation for continuous quality improvement and system integration.

District alliances are responsible for developing local relationships and trust between health system partners in their district, having a whole-of-system focus, and leading the development and implementation of the SLM improvement plan.

PHOs have an obligation, through the PHO Services Agreement, to participate in the development and implementation of the SLM improvement plan. $23 million of PHO performance funding is used to build capacity and capability for development and implementation of the annual SLM improvement plan. Based on the enrolment register, PHOs are paid 25% in quarter 1, followed by 50% in quarter 2 on the Ministry's approval of the SLM plan. The last 25% is paid in quarter 4 and is 'at-risk' based on achieving milestones.

The settlement of the remaining 25% of SLM payment has generally been based on whether the alliance implemented the plan. The Ministry makes this decision, and so far no such payments have been withheld despite milestones being frequently missed.

## Limited options to enforce accountabilities or impose sanctions

We have identified an array of accountability mechanisms and note that the associated reporting requirements are standardised – the demands are the same on smaller DHBs that work within lower levels of capacity as they are on the largest. However, despite the numerous mechanisms and significant reporting required, the accountability arrangements apparently have few 'teeth', and there is little evidence of change happening as a result of accountability mechanisms being applied.

The Ministry of Health monitors the performance of the DHBs. In the case of repeated performance failure, the Minister of Health may exercise specific powers of sanction, for example appointing a Crown monitor or replacing a DHB's board with a commissioner. However, this has occurred in only rare circumstances.

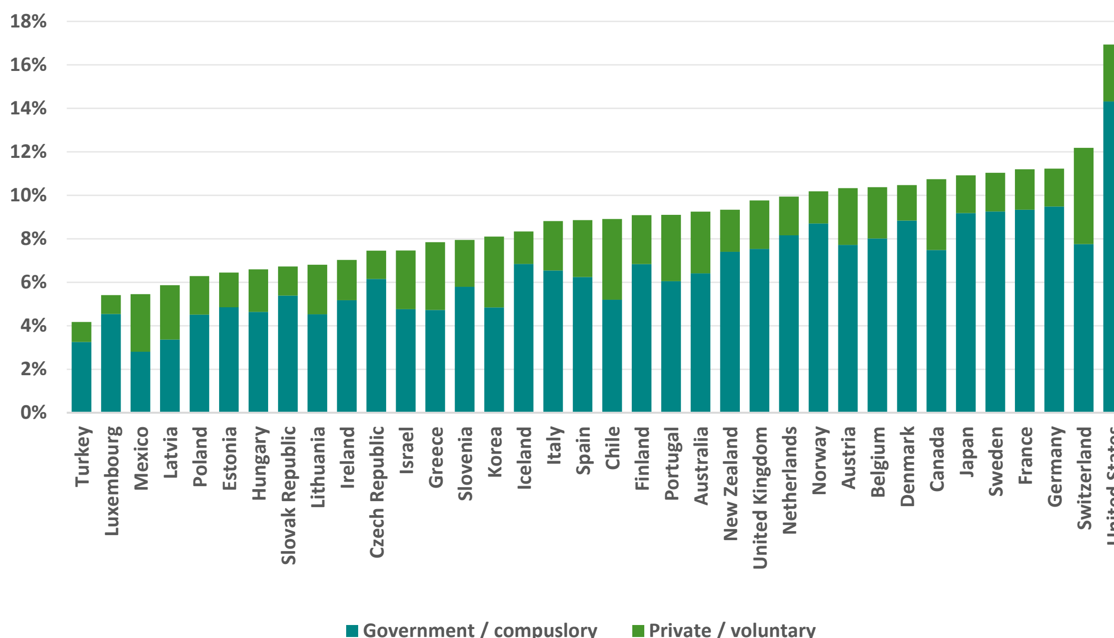
Since the establishment of DHBs, the Minister has chosen to replace boards with commissioners only three times – in Hawke's Bay DHB (February 2008), Southern DHB (June 2015), and Waikato DHB (May 2019). Appointment of Crown monitors to support boards in improving performance has occurred slightly more frequently across six DHBs (Southern DHB, Capital and Coast, Canterbury, Counties Manukau, Waikato, and Whanganui DHBs).

Though there has been significant media commentary and public commentary (particularly around the appointment of commissioners to DHBs), we have been unable to identify any formal evaluations of the impact of these appointments.

## Overview of how the system is funded

New Zealand spends around 9% of its gross domestic product (GDP) on health and disability services. This makes the health and disability system one of the largest industries in New Zealand. It also places New Zealand in the mid-range of OECD countries in terms of total healthcare spending as a percentage of GDP (see Figure 4.6).

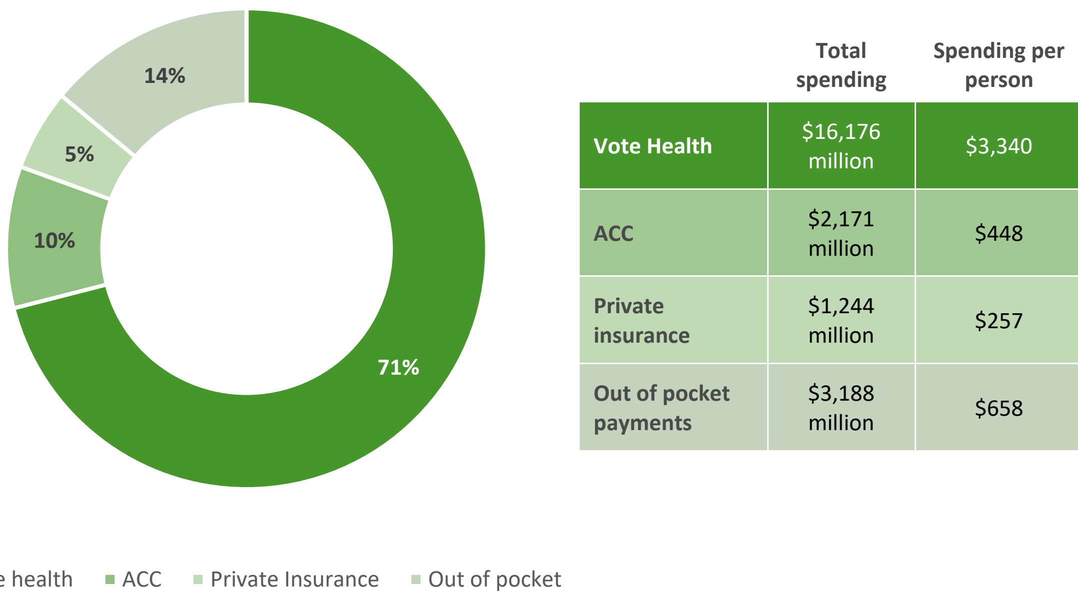
FIGURE 4.6: GOVERNMENT AND PRIVATE HEALTH SPENDING AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT BY COUNTRY, 2018




SOURCE: OECD.

Around 81% of healthcare spending is funded through Government, with 71% coming from Vote Health and 10% coming through the accident compensation scheme. The remaining 19% comes through private health insurance (5%) and out-of-pocket payments by individuals (14%). Once again, this is broadly in line with other OECD countries.

**FIGURE 4.7: DISTRIBUTION OF HEALTHCARE SPENDING, 2018**




| | Total spending | Spending per person |
|---|---|---|
| **Vote Health** | $16,176 million | $3,340 |
| **ACC** | $2,171 million | $448 |
| **Private insurance** | $1,244 million | $257 |
| **Out of pocket payments** | $3,188 million | $658 |

SOURCES: TREASURY, ACC, HOUSEHOLD ECONOMIC SURVEY (2016/17), INTERNAL CALCULATIONS.

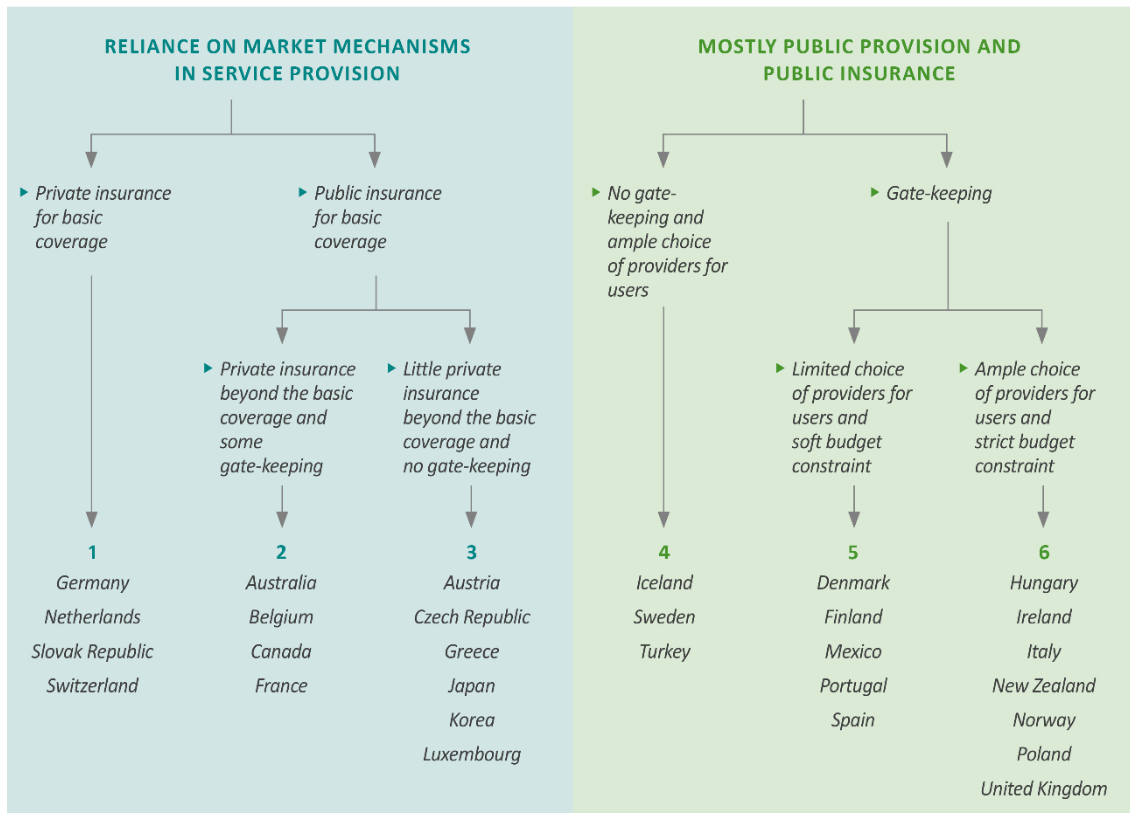
## Evidence that some system and funding arrangements perform better

The OECD's more recent classification of health systems classifies systems in two broad groups – those characterised by a reliance on market mechanisms in service provision and those characterised largely by public provision and public insurance (illustrated in Figure 4.8).

Using this classification system, New Zealand is in group 6 alongside Hungary, Ireland, Italy, Norway, Poland, and the United Kingdom. The OECD describes this group as having:

> *heavily regulated public health systems, where gate-keeping exists and the budget constraint for health expenditure is more stringent than most other OECD countries. However, there are choices available in terms of providers and complementary/ supplementary private insurance.*

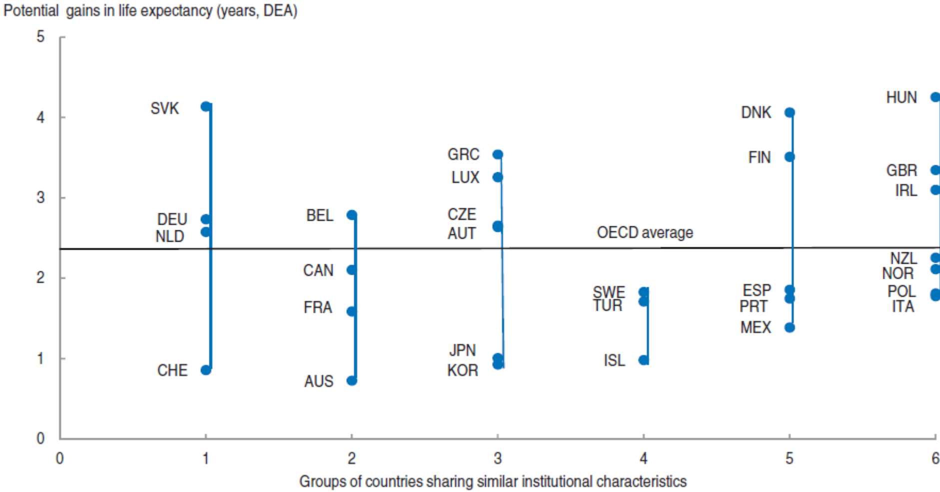
**FIGURE 4.8: GROUPS OF COUNTRIES SHARING BROADLY SIMILAR INSTITUTIONS**




SOURCE: I JOUMARD, HOELLER, P, ANDRÉ, C, AND NICQ, C. 2010. ***HEALTH CARE SYSTEMS: EFFICIENCY AND INSTITUTIONS*** (OECD ECONOMICS DEPARTMENT WORKING PAPERS 769).

The OECD undertook an analysis across 29 countries to determine whether certain institutional characteristics were related to higher life expectancy, after accounting for the level of spending and other socioeconomic and lifestyles factors. The results are outlined above in Figure 4.9.

**FIGURE 4.9: POTENTIAL GAINS IN LIFE EXPECTANCY, BY GROUP**




Note: Potential gains in life expectancy are derived from an output oriented data envelopment analysis with per capita health care spending and a composite indicator of socio-economic environment and lifestyle factors as inputs for 2007.

**SOURCE: I JOUMARD, HOELLER, P, ANDRÉ, C, AND NICQ, C. 2010. *HEALTH CARE SYSTEMS: EFFICIENCY AND INSTITUTIONS* (OECD ECONOMICS DEPARTMENT WORKING PAPERS 769).**

Overall, the analysis found that adjusted life expectancy varied more within each of these clusters than it did between clusters. Countries performing well can be found in all institutional groups.

This suggests that changing the New Zealand system to align with systems overseas would be no guarantee of success. It also suggests significant opportunities exists to improve the current system without fundamental changes in how the system is structured or funded.

### Should we move to a social insurance scheme?

Some submitters have advocated for expanding the accident compensation scheme to cover all health and disability needs, not just accidents. This would essentially move New Zealand to a social insurance model, where individuals pay insurance premiums ring-fenced to be spent on health and disability services, rather than the current model where spending primarily comes from general taxation.

Significant differences exist between the model used for accident compensation and the health and disability system. One of the foundation principles for the accident compensation scheme is that the scheme compensates for the loss that a person has suffered. This recognises that introducing the accident compensation scheme removed the right of people injured to sue for losses. The scheme is also entitlement based. If someone is entitled to cover under the scheme, the accident compensation corporation (ACC) is legislatively required to provide income compensation, treatment, and rehabilitation to return that person to their previous level of independence, but has no obligation to provide anything further. In contrast, the health and disability system is needs based and focuses on achieving equitable health outcomes for the population. This means the health and disability system does guarantee access to some services (for example, waitlists for elective surgeries), but the system also funds a wider set of services than the entitlements under the accident compensation scheme (for example, population-based health services).

The Review's Terms of Reference exclude changes to the accident compensation scheme, but allow consideration of the boundary between the scheme and the health and disability system. Given the OECD analysis cited above, it is unlikely that shifting to a social insurance scheme will in and of itself improve equity. However, as we progress our Phase Two work, we will explore what can be learnt from what the accident compensation scheme does well (such as case management), how the scheme and the health and disability system can better collaborate to improve services, and how the inequities created between individuals with similar needs arising from different causes can be better addressed.

## Financing the future health and disability system: challenges and opportunities

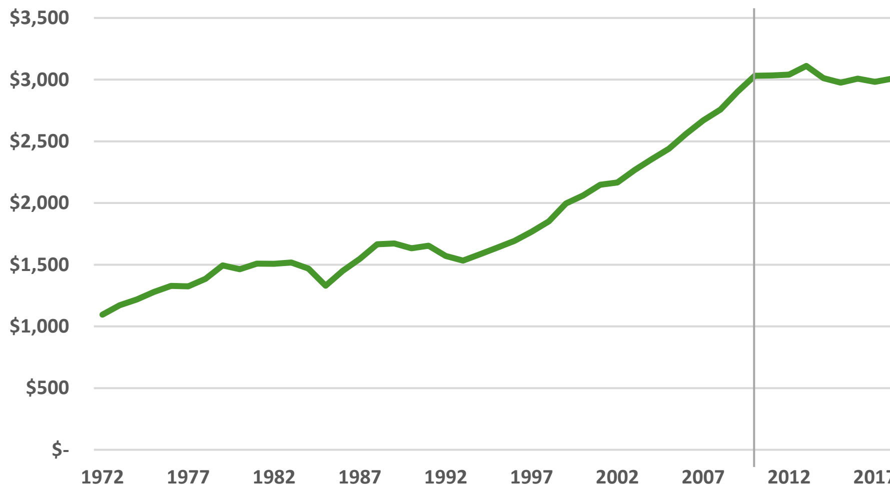
### Funding has not kept pace with increasing costs

Many stakeholders were concerned that increases in funding have not kept pace with increasing costs in the sector. Other stakeholders said the problem is not a lack of funding, but how the system functions.

Adjusting for population growth and inflation, government health expenditure had a sustained period of growth from the mid-1990s to around 2010. However, since then, real per capita spending has been flat (as shown in Figure 4.10).

Periods of little growth in funding clearly add pressure to the system and may have contributed to issues such as staff burnout and underinvestment in capital maintenance. However, the Panel is not convinced that funding pressures alone are the main reason for the current inequity of health outcomes.

**FIGURE 4.10: PER CAPITA CORE CROWN HEALTH EXPENDITURE ADJUSTED FOR INFLATION, 1972–2018**




SOURCE: THE TREASURY AND STATS NZ (POPULATION ESTIMATES, GROSS DOMESTIC PRODUCT DEFLATOR).

## DHBs are running unsustainable financial deficits

Almost all DHBs are spending more than they receive in revenue, leading to financial deficits. Some stakeholders expressed frustration that, while some areas of the system are making tough decisions to avoid deficits, other areas continue to run persistent deficits with few repercussions. Other stakeholders believe that because so many DHBs are running deficits, there is essentially no incentive not to run a deficit.

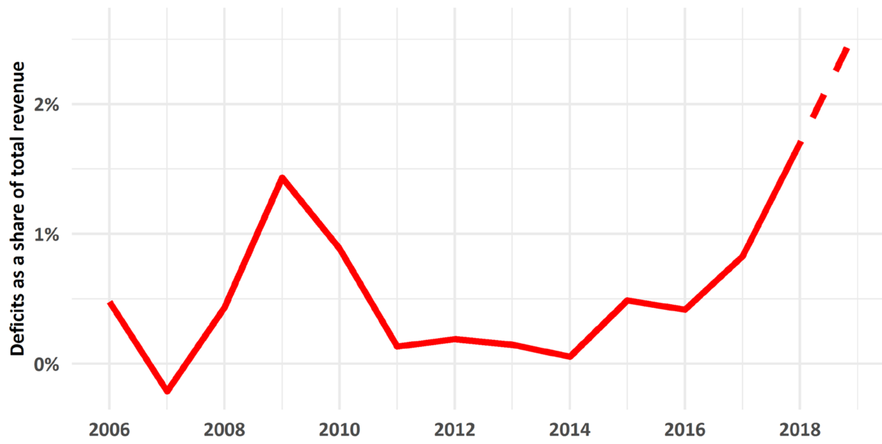
Financial deficits are not new, they have been a persistent feature of the health system for many years. In the 1990s, Crown Health Enterprises (Crown entities that delivered hospital and health services before DHBs) ran significant deficits of around 10% of revenue. DHBs were established in 2001 and ran significant financial deficits in the early 2000s.

Problems constraining spending growth are also present in other parts of the system. For example, disability support spending, controlled by the Ministry of Health, has consistently exceeded appropriated funding in the last few years, leading to funding being redirected.

Deficits as a percentage of revenue are now at the highest level since the mid-2000s, and partial data from 2018/19 suggests they will continue to grow in the short term.

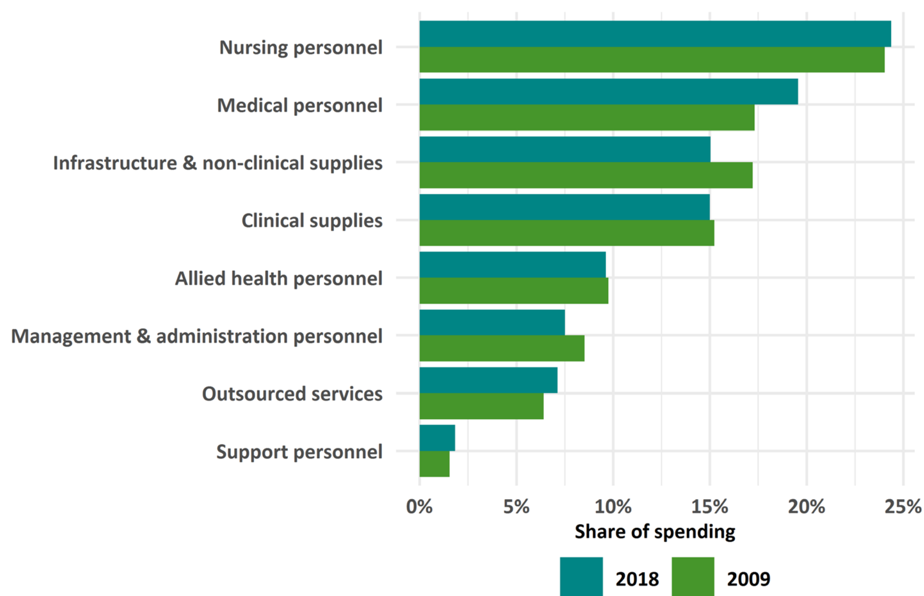
Personnel are the largest cost to DHBs, making up around 63% of the cost of providing services. Since 2009, a greater share has been spent on medical personnel and a smaller share on management and administrative personnel, infrastructure, and non-clinical supplies (see Figure 4.12).

**FIGURE 4.11: DHB DEFICITS AS A PERCENTAGE OF TOTAL DHB REVENUE (INCLUDING INTER-DISTRICT FLOWS), 2006–2018**




SOURCE: MINISTRY OF HEALTH, DHB FINANCIAL ACCOUNTS.

**FIGURE 4.12: SHARE OF DHB SPENDING BY CATEGORY, 2009 AND 2018**

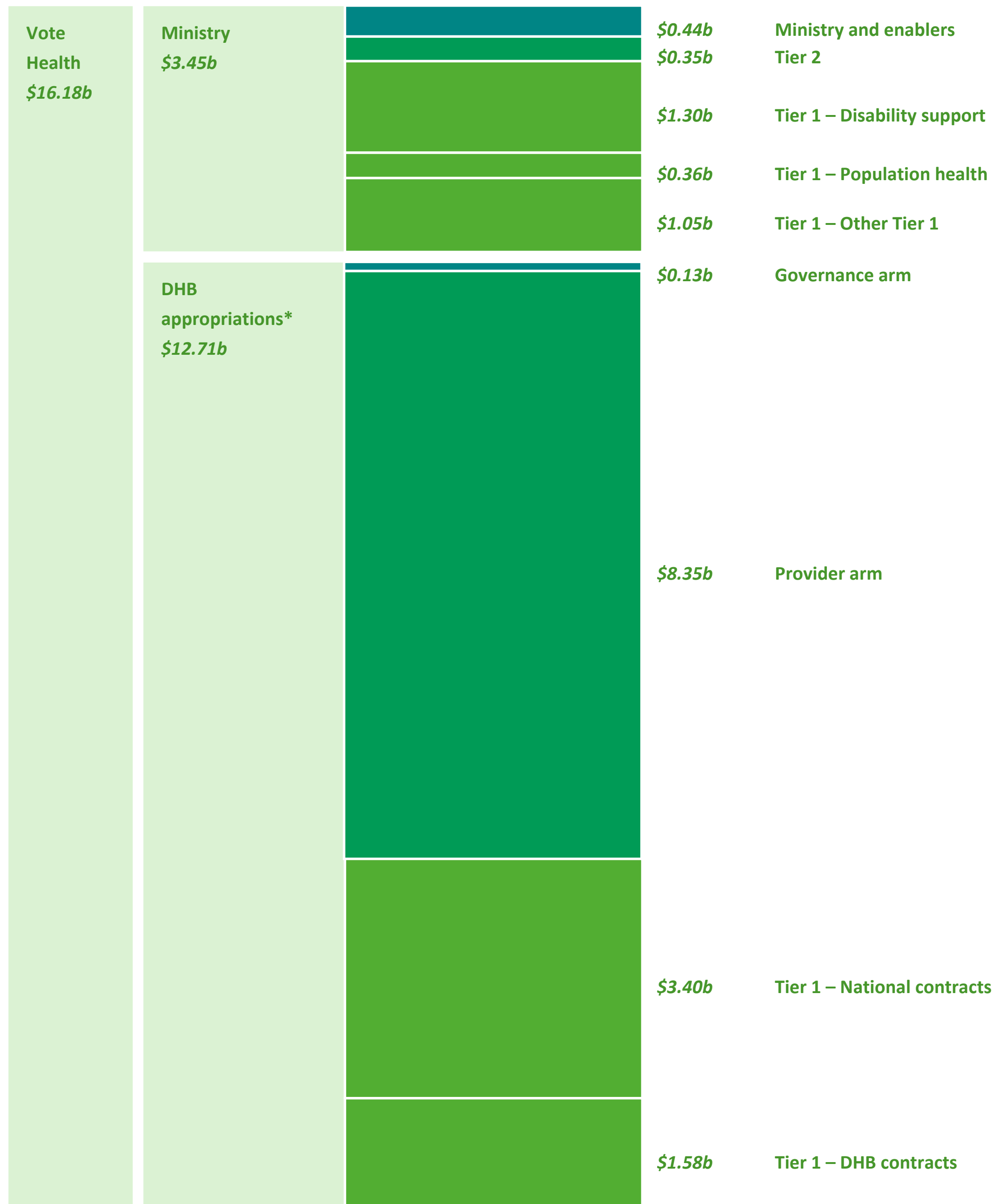



SOURCE: MINISTRY OF HEALTH, DHB FINANCIAL ACCOUNTS.

## How funds flow through the system

The allocation of Vote: Health in 2017/18 is summarised in Figure 4.13.

FIGURE 4.13: BREAKDOWN OF FUNDING APPROPRIATED THROUGH VOTE HEALTH, 2017/18




Notes:
Tier 1 services are the broad range of services and other activities that take place in homes and local communities.
Tier 2 services are public and private hospital services.
* The figures do not sum the total funding in DHB appropriations because DHBs receive revenue from other sources.

About three-quarters of public health spending is devolved to New Zealand's 20 DHBs. The Ministry of Health retains a quarter of public health spending for purchasing services including disability support, population health, and child health services (see Figure 4.13).

### Concerns over funding allocations

We heard concern that a disproportionate share of funding is being spent on hospital services, leaving little for other services such as primary care or population health services.

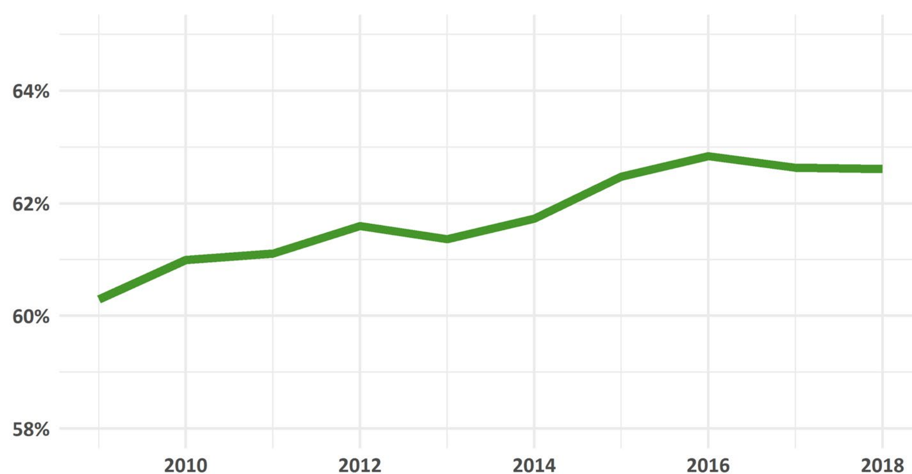
Evidence exists of growing spending on hospital services. DHB revenue can be allocated to services provided directly by the DHB (the 'provider arm') and services contracted with other providers (the 'funder arm'). The provider arm provides predominantly Tier 2 services (public and private hospital services). The funder arm provides predominantly Tier 1 services (the broad range of services and other activities that take place in homes and local communities).

Over the past decade, revenue allocated to DHB provider arms as a share of total DHB revenue increased (see Figure 4.14). Provider arm spending grew 47% from 2009 to 2018, compared with 34% growth in funder arm spending.

However, from 2004 to 2008 the share of spending in provider arms actually fell from around 62% to around 58%. This was due, in part, to an increase in spending on primary care following the release of the Primary Health Care Strategy.

It is more difficult to establish why growth in hospital spending since 2009 occurred. Submitters and other reviews have noted that DHBs owning hospitals may lead to a conflict of interest. DHBs may be biased towards spending in their provider arms, since they have greater control over this spending and, potentially, because hospital employees can have a greater influence over decision making.

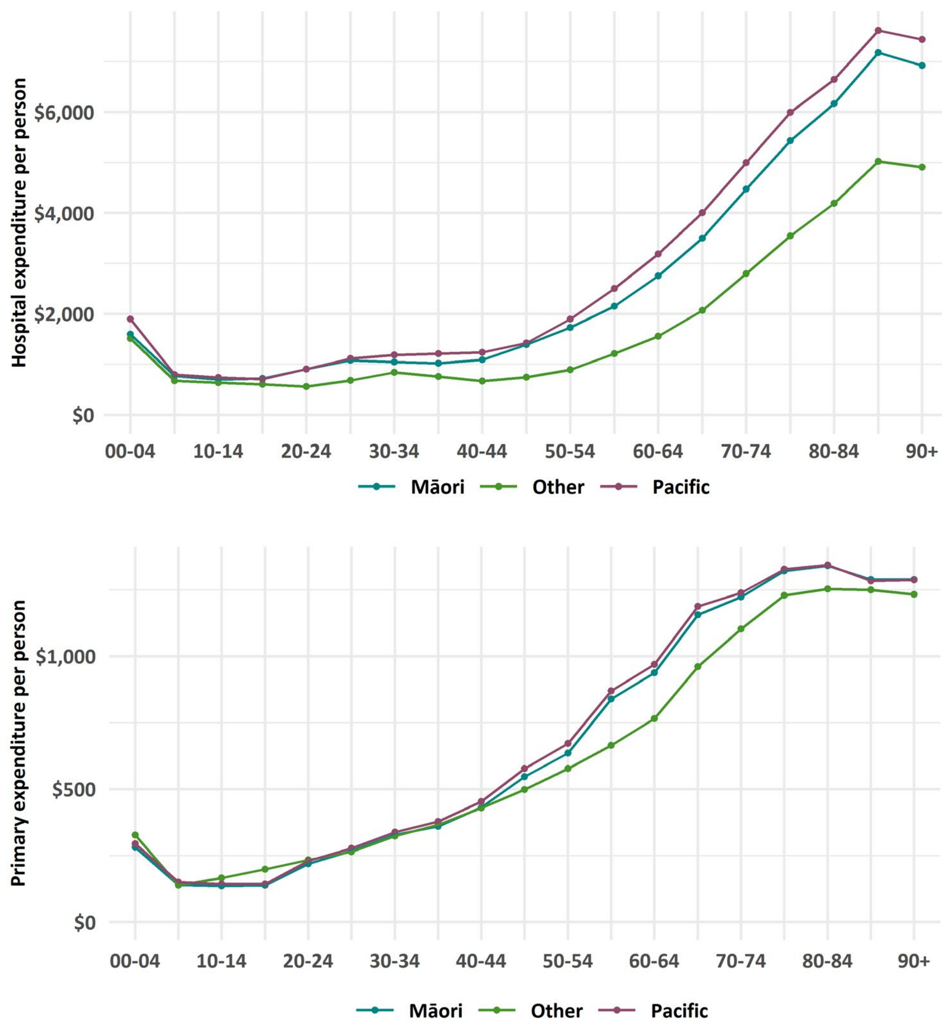
**FIGURE 4.14: SHARE OF TOTAL REVENUE ALLOCATED TO DHB PROVIDER ARMS, 2009–2018**




SOURCE: MINISTRY OF HEALTH, DHB FINANCIAL ACCOUNTS.

However, other factors may have contributed to higher provider arm spending, including accountability mechanisms that focus on hospital services. Significant variation also exists in spending within DHB provider arms. For example, DHBs also own and control the provision of many mental health services, yet growth in spending on these services has been slower than overall funder arm spending.

**FIGURE 4.15: PER PERSON SPENDING BY AGE GROUP AND ETHNICITY, HOSPITAL SERVICES COMPARED WITH PRIMARY SERVICES**




SOURCE: MINISTRY OF HEALTH.

### Is funding being spent equitably?

A major concern we heard is that funding is not being equitably spent on population groups with high needs. In some instances, this was linked to a discussion about the population-based funding formula (PBFF) (which is the tool used to distribute DHB funding according to the needs of each DHB's population), in other instances it was raised as a more general concern.

The first graph in Figure 4.15 shows average per person expenditure on hospital services by age group and ethnicity. Older age groups have more, and more complex, health needs, so have higher levels of expenditure. All Māori and Pacific age groups have higher levels of expenditure than non-Māori non-Pacific (other) age groups. However, this difference is very small for age groups under 20. These expenditure comparisons do not reflect whether the expenditure is sufficient to meet the needs of different populations.

The second graph in Figure 4.15 shows average per person expenditure on 'primary services' by age group and ethnicity. Primary services include PHO services, immunisations, pharmaceuticals, pharmacy services, and laboratory services. Again, older age groups tend to have higher levels of expenditure. However, for Māori and Pacific people aged under 45, spending per person is roughly the same as for non-Māori non-Pacific people. Māori and Pacific children (under 19 years) have lower levels of expenditure than non-Māori non-Pacific children. This is particularly concerning, given that around 75% of Māori and 80% of Pacific people are aged under 45 years. Māori and Pacific peoples aged 45 and over have higher levels of expenditure, but this difference is smaller than in hospital and community services.

### Different appropriations grow at different rates

Most government spending in the health and disability system comes through Vote Health. Funding is allocated to 51 appropriations within Vote Health that define what public money can be spent on. Each DHB has its own appropriation, but there are also appropriations for non-DHB services such as national disability support services and population health services.

Vote Health has 'fixed nominal baselines', which means the amount of funding received each year does not automatically increase to match volume, population, or cost increases. Instead, in each Budget cycle, the Minister of Health submits bids requesting additional funding for new initiatives or to help provide existing services given population and cost pressures. Separate bids are submitted for different parts of Vote Health, and some parts (such as population health services) have not received cost pressure increases.

Cabinet has the discretion to reject any Budget bid. However, in practice, DHB cost pressures have always been at least partially funded (that is, funded with an efficiency adjustment).

Therefore, different parts of Vote Health grow at different rates depending on the Government's competing priorities. For example, spending within the public health service purchasing appropriation was flat or falling in nominal terms from 2010 to 2018, while DHB appropriations grew around 3.2% per year over the same period. National elective services grew more rapidly at around 4.9% per year.

Some votes and appropriations do not have fixed nominal baselines. Appropriations covering benefits and superannuation are automatically adjusted based on forecasts of future benefit increases and increases in the number of benefit recipients. Eligibility rules and changes in benefit rates are set in legislation, so there is little discretion to change spending. In contrast, appropriations for education are automatically adjusted for forecast changes in student numbers, teacher numbers, and teacher pay rates. Further consideration needs to be given to whether changes to budget-setting procedures would provide any greater certainty for the health and disability system in the future.

## Population based funding formula is complicated and poorly understood

Most DHBs support a population- and needs-based method of allocating funding. In theory, this method can lead to an equitable share of funding to different areas based on population size and need. However, the PBFF is difficult to understand, and many DHBs feel they are not receiving an equitable share of funding.

The process of allocating funding to DHBs is complicated and has many different stages. The full process is described in a supporting working paper[139], and involves five service models, three adjustors, top-sliced funding that isn't allocated on a population basis, and other factors. In addition, DHBs also receive funding through contracts with the Ministry of Health or services such as electives and population health, direct contracts with ACC and other government entities, and other sources such as donations.

It is not surprising that such a complicated process is not well understood. However, limited transparency of what data is used and how it is used, leads to concern that the allocation process may be flawed.

For example, the Waitangi Tribunal noted that in the 2013 Census Māori were undercounted by 6.1% compared with 1.9% of non-Māori. Some giving evidence to the Tribunal believed that this undercounting led to lower funding for Māori, because PBFF allocations are based on census data. However, the PBFF is not based on census-night counts, but on 'estimated residential population', which Statistics New Zealand publishes separately. These estimates use census data, but also adjust for factors including people not filling out a census form and people choosing not to report their ethnicity in the census. They are also updated annually using birth, death, and migration data (and including PHO enrolment data).

The appropriateness of the PBFF allocation is limited by the quality of available data. In total, around 12% of DHB spending could not be modelled due to lack of data, and this share is as high as 24% in some service areas.

Because the PBFF uses past service use to determine the funding allocations for different populations, it does not capture unmet need. An unmet need adjustor is included to account for this, but this adjustor accounts for only about 1.5% of overall funding. This suggests the health and disability system meets 98.5% of all health needs, which appears implausible given the large inequitable difference in health outcomes between population groups.

### DHB funding growth can be volatile and DHBs have little forewarning

We heard concerns from DHBs that they have little advanced notice of the funding they will be receiving in the next financial year, limiting their ability to develop annual plans. Furthermore, the increases in funding they do receive can be quite volatile and can appear unrelated to the growth in population or health need in their district.

If the process for calculating each DHB's level of funding is complicated, then calculating each DHB's annual funding increase is doubly so. Each DHB's funding increase in a particular year will depend on multiple factors, including:

- the overall increase in DHB funding decided by Cabinet
- changes in the relative size and composition of each DHB's population
- changes to top-sliced funding
- other technical changes (such as debt to equity transfers)
- revisions to past population estimates.

The result of this process is increases in individual DHB funding that are hard to predict and that can appear to be unrelated to underlying population growth or changes in demand.

Revisions to past population estimates can be significant and are often unrelated to actual population growth. For example, Auckland DHB is projected to be the fastest growing DHB in 2019/20, yet its funding growth is slightly less than average in 2019/20. This was because Statistics New Zealand revised down the estimated population of Auckland by 0.8% based on the most recent data. In contrast, Wairarapa DHB's population growth was lower than average in 2019/20, yet it received the largest percentage increase in funding, because of a significant upward revision in its estimated population.

We have heard from DHBs that the volatility in their funding growth and the lack of an early funding signal reduces their ability to plan future services. Although an early funding signal may provide some support for DHB planning, it is certainly not the only barrier to more effective planning in the sector. For example, half of the annual plans for the 2014/15 financial year had not been signed off five months into the financial year, even though an early funding signal was provided. Furthermore, an early funding signal would do little to address the significant absence of long-term planning in the system.

# Directions for change: Governance and funding

The function of the health and disability system is to improve the health and wellbeing of the population it is set up to serve. Too often in the past, the way the system has been designed or managed appears to have been driven by the interests of the system rather than the interests of those most in need of help. Inequitable outcomes have been the result.

The Panel is strongly of the view that priority for change must be given to areas that will most benefit those who are currently least advantaged.

### A MORE COHESIVE SYSTEM WITH CONSISTENT AND EFFECTIVE LEADERSHIP

- *The Panel believes that while the shape of the particular structures within the health system are important, they are not the key reason for the lack of effective performance.*
- *If New Zealand is to develop a system that operates effectively with equitable outcomes throughout, it must first operate as a cohesive, integrated system that works in a collaborative, collective, and cooperative way. Behavioural and attitudinal changes are needed. These changes need to be led from the centre and applied consistently throughout the system.*
- *To this end, the Panel believes a clearly defined set of values and principles that appropriately reflects the diversity of cultures and Māori as tangata whenua should guide the behaviours and operation of the entire system.*

### A CLEARER DECISION-MAKING FRAMEWORK

- *The Panel believes a clearer decision-making framework is needed across the system that allows decisions to be made in a timely manner, made at the appropriate level, and enforced effectively.*
- *Decisions should support the best use of available resources across the whole system, rather than being driven by the interests of a region, discipline, or organisation. Governors should be responsible (and held accountable) for both local and system-wide impacts.*

### COLLABORATIVE LONG-TERM PLANNING

- *The Panel strongly believes that the lack of mandatory longer-term integrated planning throughout the system makes it impossible for communities or government to have confidence in the effective performance of the system. Planning needs to be strategic and undertaken within a system-wide framework.*
- *Effective strategic planning will require more systematic community and stakeholder engagement, both within the health and disability sector and intersectorally. Such engagement will be necessary in both the development and implementation of plans. Iwi and Māori must be fully involved.*

#### A SYSTEM THAT IS LESS COMPLICATED

- *The Panel recognises that the health and disability system will always be complex, but believes the objective should be to make it less complicated with fewer, not more, agencies.*

#### CONSUMER REPRESENTATION

- *The Panel believes that if the system is to be reoriented so it purposely focuses on the needs of the community it is serving, communities need more effective avenues for guiding the direction of health service planning and delivery. The Panel has not formed a definite view on whether DHB elections are an effective or an essential way of achieving this.*

#### ACCESS TO ENHANCED ANALYTICAL AND BACK-OFFICE FUNCTIONS

- *The population and geographic sizes of the current DHB regions vary significantly, yet all DHBs are mandated to perform the same range of functions. The Panel believes that before deciding the solution is to have fewer DHBs, it is worth considering whether the system as a whole should provide more analytical or back-office functions to smaller DHBs in other ways.*

#### MORE FUNDING ALONE IS NOT THE ANSWER

- *The Panel recognises that there will always be worthwhile ways to spend more money within a health and disability system and that the relatively slow growth in expenditure in recent years has added to stresses within the system.*
- *Projected changes in demographic and disease profiles mean demand for health services will continue to grow strongly, which, along with recent adjustments in staffing costs, will require further increases in the overall funding envelope over time, even with improvements in efficiency.*
- *The Panel recognises however, that increasing funding alone will not guarantee improvements in the equity of outcomes. The Panel's initial focus is, therefore, on how the system could operate differently to make better use of whatever financial resources are available to it.*
- *The Panel also recognises that previous funding levels have not been the sole cause of the system continually running financial deficits and believes accountability mechanisms need to change to hold the system more accountable for staying within future funding paths.*