Section B: Settings / Ngā whakaritenga o te pūnaha

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

While health and disability systems worldwide are inherently complex, the New Zealand system can and should be simplified. Changing a health and disability system's structure can be very costly and disruptive, divert attention from delivering care and can impede innovation. Therefore, wherever possible, the Review's recommendations focus on making the system's current arrangements work better.

However, to generate the significant change in how the health and disability system operates, some structural change is proposed. The roles of the Ministry of Health and DHBs are refined, two new organisations are created (Health NZ and the Māori Health Authority) and one is disestablished (the Health Promotion Agency) and new planning and funding arrangements are proposed.

Findings from the Interim Report

The Interim Report identified the following potential changes to how the health and disability system operates, how plans and decisions are made, how consumers are involved and how it is funded. These are underpinned by proposals that emphasise that the system's design must be driven by a focus on population health, improving Māori and Pacific health outcomes and equity, and be committed to te Tiriti o Waitangi principles. (seer Hauora Māori Chapter).

Interim directions for change: governance and finance

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.

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 with other sectors. 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 with a clearer decision-making framework

- 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 agencies.
- 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.

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.

Funding

- 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.
- 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.

These issues are discussed further below.

A cohesive system

Cohesion requires clarity on where functions reside, how decisions are made and how organisations are held accountable.

For the health and disability system to perform better and more equitably, coordinated service delivery requires stronger, direct leadership with direct accountability to the Minister. In addition, the system needs clearer direction and accountability for what it must achieve. The World Health Organization describes this concept as 'system stewardship'. This means taking responsibility for the health and wellbeing of the population and guiding the whole health system.

System stewardship involves three broad tasks:

- setting the vision for, and direction of, the health and disability system
- collecting and using intelligence, such as data and evidence based research
- exerting influence on organisations working in the health and disability system through regulation and other means.[40]

Initially, the Review considered whether it was feasible for the Ministry to build capability and capacity to undertake both stewardship and service delivery leadership roles. However, system stewards - or chief policy advisors - and service delivery leaders need different 'organisational brains' and skillsets. The service delivery function needs strong business acumen, focused clinical leadership and expertise in delivering health services so services can be provided effectively, efficiently and in an integrated way, across the country.

Well performing health systems overseas, for example, in many European countries (such as Norway and Finland), have shown the benefits of separating the stewardship role from the service delivery role. The Review concludes that the health and disability system would benefit from a similar structure.

Reinforce and focus the role of the Ministry of Health

Under this new model, the Ministry would be the chief steward of the health and disability system (alongside the Māori Health Authority) and chief advisor to the Government on strategy and policy, to improve health and equity of outcomes. This would streamline the Ministry's current role (eg, it would no longer be responsible for funding services and managing contracts). However, having a more focused purpose gives it greater potential to improve health outcomes and equity.

The Ministry's core functions would be:

- setting clear direction and strategic policies
- providing population health leadership and defining long-term health outcomes
- developing and overseeing health legislation and regulations
- monitoring the overall performance of the health and disability system
- delivering statutory duties (such as the Director of Public Health) and strategic clinical leadership (for example, through roles such as the Chief Nurse)
- leading the Vote Health budget process.

The Ministry would also be responsible for scanning the horizon, so the system can respond to pressures appropriately and in good time. It would also be expected to use what it learns from the system, and other international systems, to reset the strategic direction. The Ministry would need to work with the Māori Health Authority so that its strategic policy reflects mātauranga Māori and its aims to achieve equitable health outcomes. The Ministry would need strengthened population health expertise, so it could build illness prevention and wellbeing promotion into every part of the health and disability system. It would have responsibility for leading intersectoral collaboration with other central agencies.

The statutory duties of the Director-General of Health, the Director of Public Health and Director of Mental Health and Addiction Services and other professional leadership roles would not change.

Establish the Māori Health Authority

As discussed in the Hauora Māori chapter of this report, a Māori Health Authority would sit alongside the Ministry. It would lead the policy advice with respect to hauora Māori, act as kaiarataki or steward for hauora Māori and ensure the health and disability system is committed to achieving equity of outcomes for Māori.

The Māori Health Authority's core functions would be:

- advising the Minister on all aspects of Māori health policy
- monitoring and reporting to the Minister on the performance of the health and disability system with respect to Māori health outcomes and equity
- partnering with the system to ensure that mātauranga Māori and other Māori health issues are appropriately incorporated into all aspects of the system
- managing the development and implementation of the Māori workforce strategy and plans
- managing investment in workforce and Māori provider development and in initiatives to develop innovative approaches to improving Māori health outcomes.

The Māori Health Authority would be an independent departmental agency, reporting to the Minister of Health and working with the Ministry, Health NZ and DHBs to embed mātauranga Māori across the health and disability system and achieve improved health outcomes for Māori. (See Hauora Māori chapter for further detail on the roles and functions of the Māori Health Authority.)

Establish Health NZ

A new crown entity provisionally called Health NZ would be responsible for leading health and disability services delivery throughout New Zealand. It would be accountable to the Minister of Health for the overall performance of the health and disability system delivery and its impacts on improving health outcomes and equity.

Health NZ would:

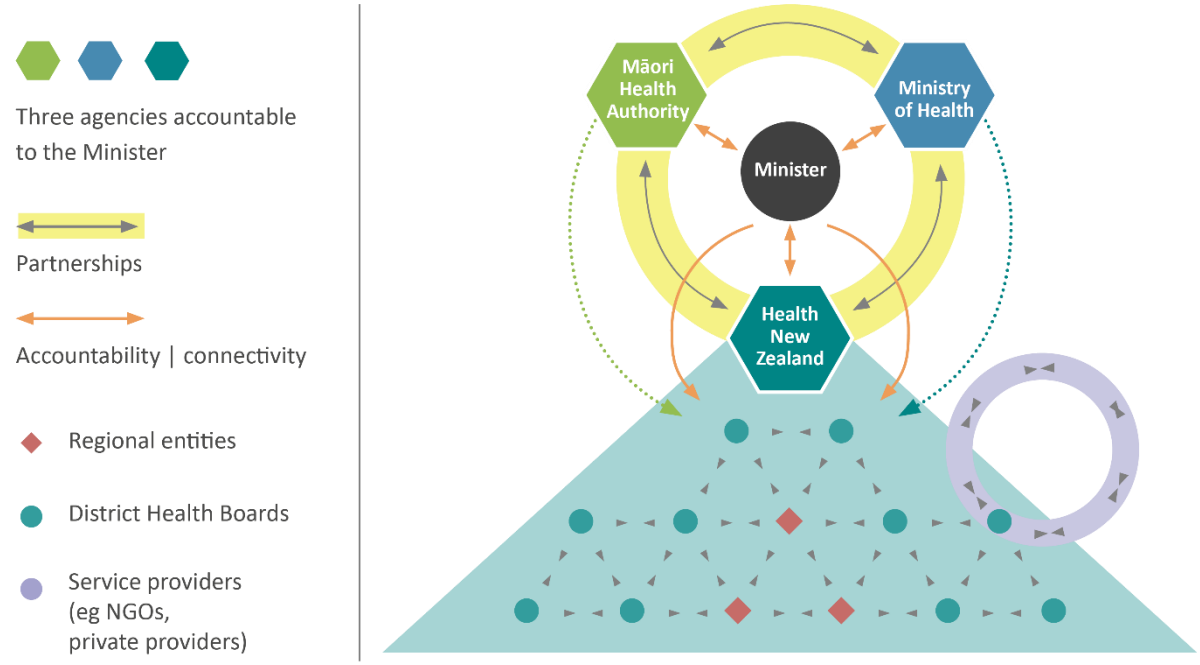
- drive consistent operational policy and lead delivery of health and disability services across the country. All DHBs would be required to operate cohesively subject to Health NZ leadership
- be accountable to the Minister for the overall financial balance of the system
- drive continuous improvement both clinically and financially and address unwarranted variation in performance
- undertake common functions for the system, eg strategic employment relations
- drive the development of new commissioning frameworks ensuring that it partners with the Māori Health Authority to include specific provisions for commissioning Māori health services

Health NZ would work in partnership with the Māori Health Authority to ensure mātauranga Māori is embedded in the health and disability system and, in particular, to support DHBs in commissioning services for Māori populations.

The Review proposes that Health NZ would be governed by a board made up of eight member and a Chair, with 50/50 Crown/Māori representation, with board membership drawn from DHB board members in each of the regions.

The figure below illustrates the relationships between the Ministry, Health NZ, the Māori Health Authority and DHBs. (Changes to the role of DHBs is discussed later in this section.)

Figure 4.1: Integrated system overview



Increase population health expertise in the Ministry

The Review recognises that the best way to achieve equity and strengthen the sustainability of the health and disability system is to put much more focus on embedding population health into all levels of the system.

Population health is proactive in promoting and protecting health and keeping people and populations as healthy as possible. It recognises that the health of populations is shaped by the social, economic, cultural and environmental contexts in which people live, learn, play and work, and that responses are required across the health and disability system and other sectors to create environments that support health and wellbeing.

Population health has an inherent, explicit focus on equity. Working to eliminate systemic inequities in health outcomes requires:

- looking at which groups are most impacted
- understanding how and where inequities manifest
- recognising the socioeconomic determinants that underpin health inequity
- implementing comprehensive strategies to eliminate or reduce inequities.

Using metadata to understand population health and service activity is critical not just for national health surveillance, but also for strategic planning, health needs assessment and service design. Rich datasets already exist for health and disability services, as well as related services such as social development and education. However, the health and disability system must become more skilled at using data to identify variations in factors and conditions that influence the health of different populations, and to apply this knowledge to commissioning decisions.

As the steward of the health of New Zealand populations, the Ministry should lead the sustained effort and development of the expertise needed to support this change. Capability to provide advice should also be available from the Māori Health Authority (in relation to Māori population health expertise), and Health NZ (that would require analytic capability to drill down into the data). However, these capabilities must also be mandated at a regional level to assist DHBs in strategic and locality planning that takes a strong population health focus.

Using population data and analytics must become the norm, with analysts working alongside commissioners, service designers and the frontline workforce to identify and respond to unmet need. Bringing the Health Promotion Agency's functions and expertise within the core system would also increase focus and capacity for leadership, transparent reporting and partnering to improve population health and health equity.

Roles of other statutory agencies

The roles of other statutory agencies, including Crown entities, departmental agencies and statutory boards and committees would continue as at present. Their support for improvements in population health, health equity and responsiveness is likely to become more effective as the system becomes focused on collaboration and integrated working.

Refocus DHBs and regions to operate more effectively

Hold DHBs accountable for improved health outcomes and equity

DHB boards and board members are accountable to the Minister of Health, both individually and collectively for performance locally. Currently there is no requirement or mechanism for them to be accountable for contributing to the effectiveness of the whole health and disability system.

Also, the primary intention of restructuring the health and disability system in 2001 was to devolve significant decision-making powers to DHBs but, in reality, devolution has been only partial and this has compromised DHBs' ability to make strategic decisions.

The Review concludes that it is essential to achieve the right balance between DHBs aligning with the system's strategic direction and desired outcomes, while having the autonomy to configure services to meet local needs, including responding to iwi and Māori aspirations. DHBs must be accountable for:

- improving health outcomes and equity for their local populations by developing long-term plans to meet community needs
- contributing to the system's effectiveness

DHBs need to know what decisions they can take, to whom they are accountable and how controls are delegated throughout the system. There must be clearer direction about what must be consistent nationally and greater power for DHBs to make decisions to tailor local solutions.

Facilitate more DHB regional collaboration

The Interim Report noted that DHBs replicate processes and analysis. 'Doing it once' and sharing knowledge would be much more cost-effective. The health and disability system needs to support DHBs to share their knowledge and expertise, and to collaborate with each other. Health NZ would provide increased support to encourage and facilitate regional collaboration between DHBs, with managers appointed by Health NZ to the regions.

- Some regional functions would be mandated by Health NZ (such as population health analysis and expertise, guidance and coordination, shared expertise in planning and engagement and other operational functions) while other activities would be managed by local DHBs on the basis of determined priorities.
- Regional entities should also lead the development of regional plans and facilitate other collaborative efforts on behalf of DHBs.
- Māori Health Authority would provide support and guidance on building stronger relationships with iwi and Māori.
- DHBs in each of the regions would be required to collaborate and develop a Regional Strategic Plan at least every five years. The plan would need to be consistent with the New Zealand Health Plan and complement the District Strategic Plans. These plans would cover certain services specified by Health NZ as requiring a regional focus for planning and any other services that are identified as priorities by DHBs within the region.

Reduce the number of DHBs

More consistently applied operational policies and better regional planning and collaboration would:

- simplify the structure of the health and disability system
- streamline decision-making
- allow for better use of scarce expertise and increase efficiency.

As regional collaboration increases, the Review proposes that the number of DHBs be reduced from 20 to between 8 and 12 DHBs. Health NZ should lead the process for determining the final boundaries and achieve the reduction in numbers within five years of being established.

Once the number of DHBs is reduced, there should be a corresponding decrease in the number of regions from the current four to two or three regions.

Focus each part of the system on the same values, objectives and outcomes

Develop a charter for Health NZ

Many health and disability organisations share common perspectives on and motivations for delivering services. However, while the health and disability system has legislation, plans and guidelines, there is no one place for its combined core values and goals.

The Interim Report introduced a tentative set of shared system values that were 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 whakawhānaungatanga (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.

The Review recommends a legislated Health NZ charter that articulates the expected culture and behaviours of the health workforce. The charter would influence how care is delivered in homes, communities and hospitals and help to shape how the system is governed and held accountable for its performance. Health NZ would develop the charter with the Ministry and the Māori Health Authority. It would recognise the importance of maintaining effective relationships with Māori as tangata whenua and reflect the diversity of cultures and people that make up the workforce and use health and disability services.

Develop long-term system outcomes and related performance measures

The Ministry is currently responsible for monitoring the health and disability system's performance; it reports monthly to the Minister of Health (and sometimes the Minister of Finance). District health boards are subject to accountability mechanisms, and financial and non-financial performance reporting requirements. The Ministry also uses the System-Level Measures Framework.[41] It is designed to improve health outcomes by helping DHBs implement specific quality improvements.

Other organisations, such as the Health Quality & Safety Commission (HQSC), are also involved in quality improvement; its HQSC's Atlas of Healthcare Variation[42] is a well-developed tool that shows variations between DHBs' services and health outcomes.

Despite the volume and variety of reporting by the sector, there isn't a clear and accessible way to understand and track performance against population health outcomes.

To improve cohesion within the health and disability system, the Review recommends that the Ministry develops a set of long-term outcomes and related performance measures. These would be set out in the NZ Health Plan and integrated into the system's planning and prioritisation activities and accountability arrangements. Health NZ would lead different parts of the system to work together to achieve the long-term outcomes, potentially agreeing local targets and priorities for individual DHBs to focus efforts appropriately.

System leaders are empowered to be effective

The Interim Report identified the need for values-driven leaders working throughout the system to lead and create a culture that learns, improves performance, reinforces accountability and embraces mātauranga Māori.

Leadership capability is inextricably linked to the design, functioning, purpose and culture of a system and the organisations within it. The institutional changes recommended to provide clearer direction for the system and to establish shared values and behaviours would help to create a climate that enables leaders to work effectively.

This section proposes:

- system changes to support DHB boards to govern effectively
- steps to increase leadership capability.

Enable DHB boards to govern effectively

The New Zealand Public Health and Disability Act 2000[43] sets out the composition of DHB boards. Local communities elect seven members every three years, and the Minister of Health appoints up to four more members.

Elected boards have led to blurred accountabilities. While DHB boards and board members are accountable to the Minister of Health, locally elected members are often focused on local priorities and issues.

The public's interest in DHB elections and voting for Board members is declining; less than half of eligible people vote. While DHBs are sometimes considered in parallel with local government there is a fundamental difference; unlike councils DHBs are not responsible for generating revenue to cover their expenditure, so there is no counter balance to the drive to advocate for more services for the local population.

DHBs are complex operational entities and are often the largest employer in their local area. It can be challenging to ensure that a DHB board has the appropriate balance of competence and experience to effectively govern a large organisation. Governance skills, and an understanding of health systems, concepts of population health and equity, cultural safety and financial stewardship are needed (with additional professional expertise provided from the executive leadership team). Effective governance also requires board members to be free of serious conflicts of interest.

This challenge of ensuring an appropriate range and balance of skills is currently compounded by:

- the Minister of Health being limited to appointing only a third of each board
- DHB staff being entitled to stand for their local DHB election, which often presents a real conflict of interest.

The Review concluded that DHB elections are not the best way to ensure boards have the capability to effectively govern. A competency-based approach to identify and recruit board members should be introduced with robust processes to support the Minister appoint board members.

Local communities could nominate appropriately experienced individuals for consideration but DHB employees would be ineligible.

Create a climate for leaders to develop and work effectively

Within a country of just under five million people, there is a limited pool of experienced leaders with high-level skills and experience. This means steps must be taken to build leadership capability from within the health and disability system.

Effective leaders are people who:

- strongly align with the system's purpose and values
- have extensive health and disability system experience
- can work in environments where responsibilities are distributed across organisations and teams.

Evidence supports processes that identify people with potential leadership from within the system and giving them opportunities to learn from experience and collective development. These opportunities help people gain broader perspectives and a better understanding of different cultures; become more adaptable, empathetic and responsive; and make them better communicators.

Health NZ must create ways to identify emerging leaders and nurture people with leadership capability from within the existing health and disability workforce, in particular, giving them opportunities to learn from broader experience and collective development.

Health NZ must also ensure it provides ongoing training for DHB board members to build and develop the capabilities they require to govern effectively**.**

There is also a growing expectation that public sector leaders and their staff have a higher level of cultural competence and ability to work effectively with Māori. The recent Public Service Reforms identified Te Ao Tūmatanui – Strengthening the Māori Crown relationship as one of its five focus areas. The proposed new legislation includes a specific clause to 'support the Crown in its relationships with Māori under te Tiriti o Waitangi / the Treaty of Waitangi'. Public service leaders would be required 'to develop and maintain the capability of the public service to engage with Māori and understand Māori perspectives'.[44]

Communities and their needs drive the system

Improving population health outcomes and equity requires the system to truly focus on communities and what they need. The Review considers three changes are required for a responsive system:

- give communities a *real say* in the system
- get people and communities better involved
- partner with other sectors to respond to the economic, environmental and social impacts on health.

The Interim Report noted the system needs to focus more on the communities and people it serves. Elections for DHB board members were intended to give communities a strong say in governing their DHB,[45] but there is limited evidence to show it has been successful.[46] [47] [48] [49] Communities need better ways to guide health and disability service planning and delivery.

International evidence shows that when health systems are open and transparent, and give *a real say* to communities, they achieve better population health outcomes[50] [51] and make more progress towards health equity.[52] [53]

Communities can easily find out about their health and wellbeing and track changes over time. They can formally influence the system, and see what changes are being made and the results of those changes. Communities with a *real say* have influence; this power sharing is especially important for communities with the biggest equity gaps.

People and communities better involved

International experience confirms that, while there's no gold-standard, there are many ways that people, communities and consumer-interest organisations can successfully influence health systems and services.[54] [55] [56] [57] [58] [59] [60]

Giving people greater choice in ways to get involved increases the number and diversity of people who do.[61] [62] Many people, especially younger people and those with less free time, may prefer non-traditional channels over traditional ones such as elections, committees and formal consultation processes.

Consumer and community input into improving health and disability services and wellness is becoming more widespread in New Zealand. There are already some successful, well-researched models of how this is being done,[63] [64] [65] and these models need to be encouraged. Long-term partnerships are one way that Māori, disability communities and consumer groups have favoured; their success requires health and disability system partners to be open, respond and reciprocate, and be committed long term.

Building learning and capacity in the community are important to develop consumers and communities' experience and ability to guide system development and service improvement. These approaches are equally important for the workforce and system leaders to develop their experience and ability to learn from consumers and communities, and to maintain effective reciprocal relationships.

Reo Ora – Health Voice

Reo Ora is an online platform developed by Waitematā and Auckland DHBs to make it easy for people to be informed, get involved and have a say. People who sign up get an email every month or so with short surveys and information about community meetings, online discussions and ways to get involved. Reo Ora helps people get involved in the things they want to and find out what happens as a result, using smart phones, assisted technology or other formats.

The DHBs use Reo Ora in different ways:

- Waitematā DHB has multiple engagement methods and community events to supplement its surveys and respond to community requests. Youth, Māori, Pacific, Asian and migrant communities have specifically influenced results. Examples include information about birthing units as a safe alternative to traditional hospital births, and activity programmes for new parents using individualised text messaging.
- Auckland DHB has detailed community health profiles for its nine local board areas, including results from surveys on community health and quality of health care. The profiles are published online and are used to plan local service improvements.[66]

Partner with other sectors to respond to external impacts on health

Health services account for around 20% of all impacts on a population's health, but only an estimated 10% of impacts on health equity across income groups.[67] The communities that have the poorest population health outcomes usually face multiple economic, environmental and social disadvantages. Changing the health system alone is unlikely to improve health equity enough. To *respond* to communities with the greatest need, the health and disability system needs to partner with and develop long-term relationships with local government, other public services, businesses and communities.[68] [69]

Effective partnerships would involve:

- the Ministry building its leadership role with other government agencies, in partnership with the Māori Health Authority, to work for community wellbeing.
- Health NZ partnering with government departments and agencies to improve integration and delivery of public services nationally
- DHBs responding better to the health and disability needs of their communities.

System informed by evidence and research

While the New Zealand health and disability system can and does use international evidence and research to inform many decisions, ensuring the system operates most effectively for the New Zealand population requires access to good local evidence, research and evaluation. This is particularly true for issues relating to hauora Māori and Pacific peoples health.

Currently that evidence is not readily available or collected in New Zealand. However there is a recently updated Health Research Strategy that sets out an ambition for a system founded on research that improves the health and wellbeing of all New Zealanders.

New Zealand's Health Research Strategy

The New Zealand Health Research Strategy[70] seeks a system that is founded on excellent research and improves the health and wellbeing of all New Zealanders.

The strategy's guiding principles (research excellence, transparency, partnership with Māori and collaboration) are well aligned with the directions of this Review. Its priorities are:

- investing in research that addresses the health needs of New Zealanders
- creating a vibrant research environment in the health sector
- building and strengthening pathways for translating research findings into policy and practice
- advancing innovative ideas and commercial opportunities.

Some of the changes envisaged by the strategy are a more inclusive process for setting research priorities and greater investment in research on health and wellbeing for Māori and Pacific peoples. Stronger community involvement as well as stronger participation in research and innovation across the health and disability sector will be key. Industry partnerships and platforms for commercialising innovations will be important, especially as a population health approach drives large-scale delivery of personally-adapted digital, screening and other innovations.

The Ministry of Health and Ministry of Business, Innovation & Employment and the Health Research Council are partners in leading implementation of the Strategy

The Review believes this would actively facilitate research, development and dissemination; this is especially important in driving change to achieving equity and embed mātauranga Māori. It would engage all parts of the workforce in research; collecting evidence and making improvements would be core activities throughout the system. Concerted leadership and culture change would be required to achieve a really effective ecosystem for research and development.

Collaborative planning

Health and disability system planning involves understanding a population's health needs and aspirations and determining what services will best meet them. Organisations must allocate resources to configure and effectively deliver services, monitor progress and identify changes needed.

There are many strategies and plans produced by the health and disability system.

- The Interim Report highlighted that they are disconnected and do not work well to support system improvements. There is currently no single national document that combines the health and disability system's expected population health outcomes that details how different parts of the system will work together.

Planning requirements are spread across different legislation and accountability documents. There is no coherent nationwide planning framework that describes how things should work and who should do what. Accountability between organisations is unclear and there is no long-term perspective in current planning.

The Treasury's Living Standards Framework[71] promotes a long-term intergenerational wellbeing approach to improve sustainability of public services. It is essential that planning for today keeps an eye to the future, and organisations must be aware of the long-term impact that today's decisions make on the health and disability system and future resources.

The system must track and respond appropriately to challenges (such as emerging technologies, population growth, ageing and redistribution, and chronic disease).

The Review recognises that planning is a key lever to transform how the system works, what it focuses on and what it achieves. There is a strong rationale to change the planning approach to ensure that health and disability services are responsive, affordable, viable and can adapt to use new knowledge and cope with today's and tomorrow's challenges.

There is also a need to ensure that people, communities and iwi partners have meaningful opportunities to engage with and influence priorities.

Establish a system-wide approach to planning

The Review recommends that there should be a system-wide planning framework to improve how organisations plan and work together.

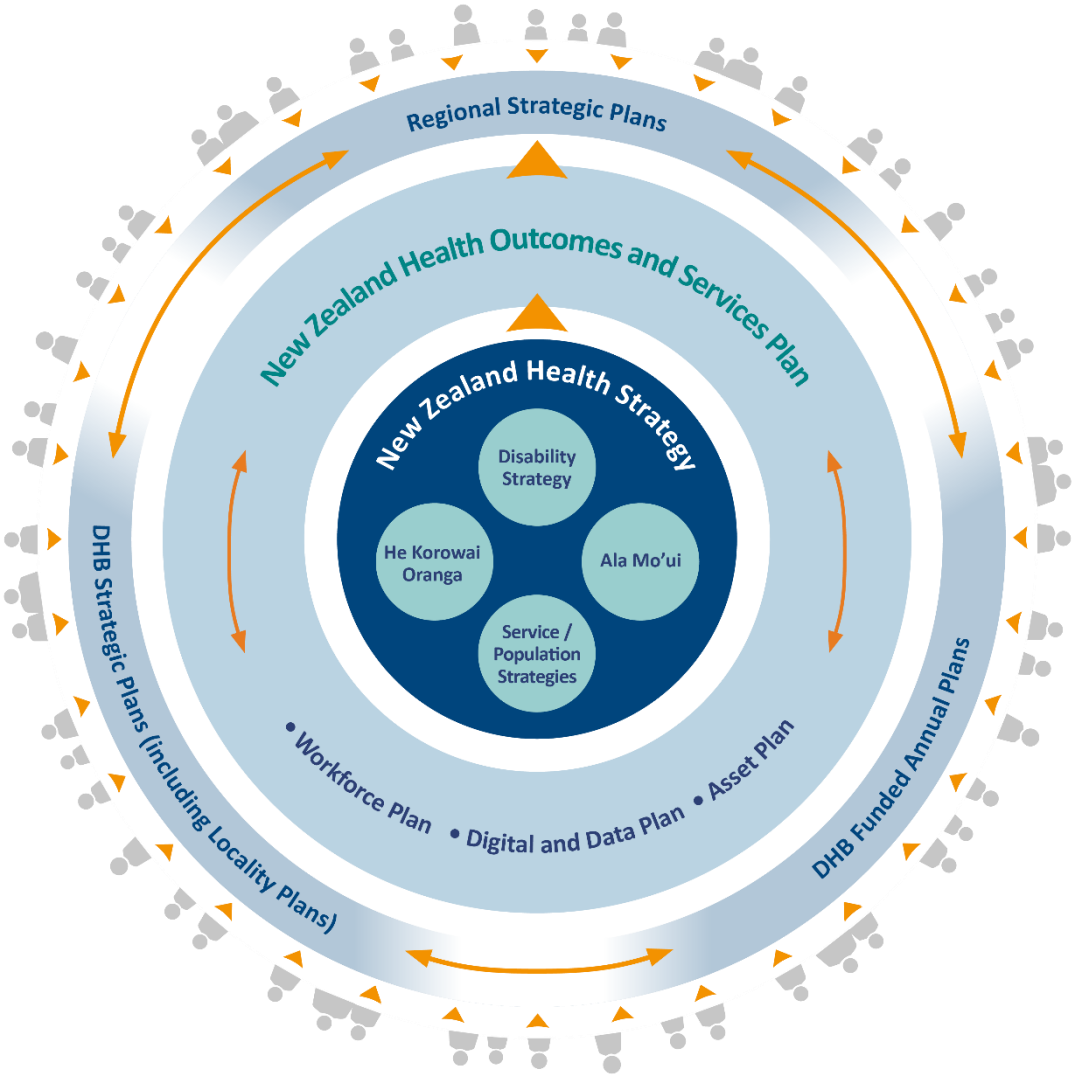
The framework should:

- define planning responsibilities and requirements and describe how organisations are accountable for their delivery and performance against plans
- clearly define the connections required between plans and support the system to review and learn from its performance through a planning cycle

- require the system to give people, communities and iwi partners relevant information about priorities, plans and the results delivered against them, and opportunities to influence them
- provide a firm context and direction to guide and support workforce development and infrastructure planning
- support clinicians to engage in planning activities
- develop and use tools that increase the system's capability to plan (for example, standardised planning processes and population health data).

The figure below illustrates the strategies and plans that would support the system's planning activities and shows the connections between them.

Figure 4.2: Overview of strategies and plans supporting the health and disability system



A long-term New Zealand Health Outcomes and Services Plan

A long term plan as set out below is proposed as a pivotal new planning document for the health and disability system.

Outline of the New Zealand Health Outcomes and Services Plan

Purpose

The New Zealand Health Outcomes and Services Plan (the NZ Health Plan) would guide the long-term strategic direction of the health and disability system over the next 10 to 15 years. It would identify the outcomes the Government expects it to achieve and how different parts of the system would work together. There would be a close working relationship between the Ministry, the Māori Health Authority and Health NZ to develop the Plan

Responsibilities

- The Ministry would take overall accountability for coordinating the development of the plan and would lead the development of the system outcome measures monitoring of the overall system's performance
- The Māori Health Authority would lead on Māori health outcomes and monitoring
- Health NZ would lead on service planning

Timeframe

The Plan would look out over the next 10 to 15 years and have greater detail on actions in the first five years.

The Plan would be refreshed every five years. In the early years, it may need to be refreshed more frequently to allow the Ministry to broaden the Plan's scope and depth, as it evolves.

Objectives

- Identify the long-term population health outcomes and related performance measures the system needs to achieve to improve health outcomes and health equity.
- Explain how different parts of the system would work together (led by Health NZ) to achieve the long-term outcomes.
- Clarify the actions different parts of the system are expected to take to achieve more equitable outcomes and to shift the focus to prevention and wellbeing.
- Track and interpret the challenges and opportunities to inform planning for changes to models of service delivery to ensure that services are sustainable and can adapt to today's and tomorrow's challenges.
- Give national, regional and local services enough context to plan their services, by clarifying which publicly funded services are available and where. Guidance would support optimal ways to configure services locally, regionally and nationally to reduce variation in access between different populations.
- Consider how highly specialised (quaternary and tertiary) services should be configured (and when such changes would need to be delivered)
- Consider the roles of public, private and NGO providers in the delivery of health and disability services, and how the system can ensure the public health system is sustainable
- Provide context to plan effectively for the system's workforce, infrastructure and equipment and data and digital technology.

District and regional strategic plans align with the NZ Health Plan

The Review recommends that each DHB should produce a district strategic plan with a 5 to 10-year outlook that is refreshed at least every five years. The Minister of Health would approve these plans, once Health NZ has advised they are consistent with the New Zealand Health Plan and are financially sustainable. A district strategic plan would:

- cover every aspect of a DHB's remit
- be based on analysis of a DHB community's health outcomes and needs
- reflect locality plans showing how Tier 1 services would be configured and delivered to each population group to improve health outcomes and to address inequities between groups
- include actions to improve the district's population health and equity outcomes
- be informed by the views of communities, stakeholders, iwi and consumers in the district, especially those with the poorest health outcomes
- identify how the DHB board would manage engagement with and reporting to its communities
- describe how clinicians are involved in and influence service planning
- describe how the DHB would work with other sectors such as local government, transport and housing to improve health outcomes.

The Review recognises the need to increase regional collaboration. Regional planning should enable DHBs to take an informed, collective view enabling them to consider the relative priorities of challenges and opportunities facing other DHBs and understand the interdependencies that may affect initiatives. Regional planning would also be essential to facilitate the reduction in the number of DHBs.

Regional strategic plans would:

- cover services identified by Health NZ that need to be planned at a regional level
- address other regional initiatives identified by local DHBs
- allow DHBs to take a collective view across the region of the relative priorities, and inter-dependencies that may affect initiatives.

The Review recommends that DHBs in each of the four regions work together to produce regional strategic plans with a 5 to10-year outlook that is refreshed at least every five years. The plans should be consistent with the NZ Health Plan and complement the relevant district strategic plans. (These plans would replace the current requirement to publish regional services plans annually.) As proposed for the district strategic plans, the Minister of Health would approve regional strategic plans once Health NZ has checked they are consistent with the New Zealand Health Plan and are financially sustainable.

DHB funded annual plans

DHBs would still be required to submit a Funded Annual Plan, which describe what primary and secondary services communities can expect to see locally and how they would access more specialised services. DHBs would be required to regularly report back to communities on health outcomes. Ministerial approval of the plan would require prior sign off by Health NZ that the plan is consistent with maintaining financial balance in the system over time.

Funding arrangements for an efficient and effective system

While health funding levels are not the major contributor to equity of health outcomes, or the sole cause of DHB deficits, changes to funding arrangements can better support the performance of the health and disability system.

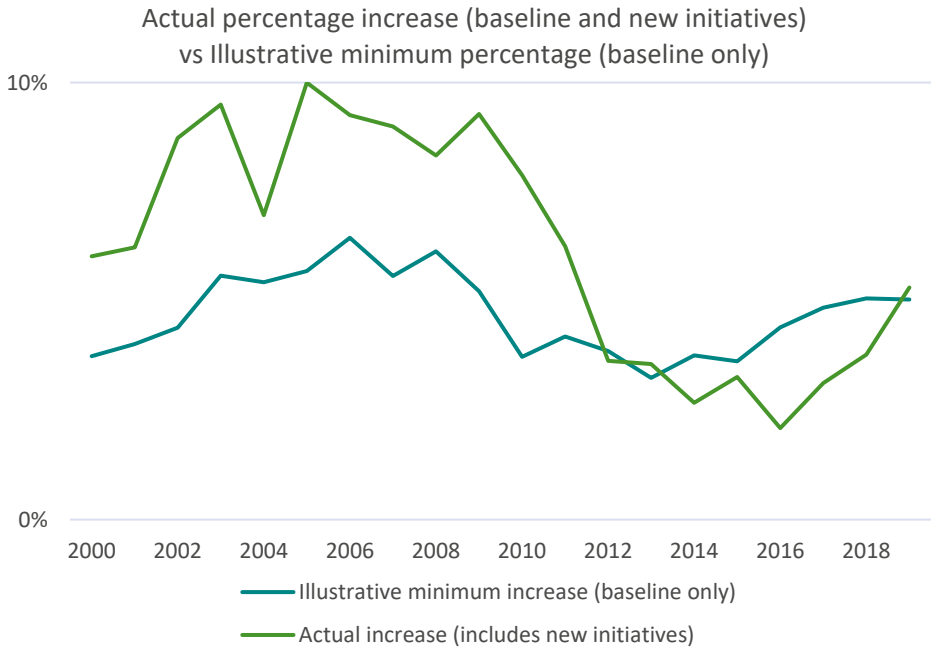
Increase predictability of base funding

Like most areas of government spending, Vote Health has fixed nominal baselines, meaning that there is no guarantee that spending on health will increase in coming years. Increases to health spending must be proposed and weighed against other spending options each year.

This does not deal effectively with the cost pressures the health and disability system continually faces. There are increasing resource requirements due to population growth and changing population needs. The system also faces increases in costs from wage inflation and other price rises (such as medicines, medical devices and other technologies). Improvements in efficiency and productivity gains may mitigate concerns but cannot entirely offset these pressures.

Additional funding is required every year to maintain the current level of health care for the average New Zealander. While Vote Health is usually increased, there have been years where the increase has not been sufficient to maintain services over time. In some years, a large proportion of the increase has been required to fund new initiatives meaning that, in practice, some parts of the system improve while others stagnate.

Figure 4.3: Annual percentage increase in Vote Health, actual versus illustrative minimum, 2000 to 2019



Source: Stats NZ, The Treasury, Ministry of Health, internal calculations

The Review concludes that guaranteed increases in Vote Health would help to maintain the overall quality of the health and disability system. The largest and third largest Votes (Social Development and Education) are not funded on fixed nominal baselines but receive guaranteed increases through legislation, allowing them to meet increased demand and cost of services without the need to compromise quality.

The Review recommends using a similar formula for setting minimum annual increases in funding. This would cover baselines (maintaining the system). Ensuring that baseline services remain funded provides advantages. It guarantees a baseline level of services that all New Zealanders can expect and reduces the requirement for cost pressure budget bids, reducing administrative burden.

The exact formula and what it includes would need to be determined but should account for growing need and growing costs, and so should factor in the increases in the:

- total population and changes in population demographics (eg, age and ethnicity)
- costs of products and services
- costs of wages.

Funding bids for new initiatives would be entirely separate and would be handled as they currently are (mainly through annual budget bids)

Such a system would provide more certainty to Health NZ and DHBs. This would help in long-term planning and facilitate commitment to multi-year contracts with non-governmental organisations (NGOs). This would have flow-on effects to the workforce: those working for NGOs for the health and disability system would have more stability, enabling NGOs to also have better long-term planning and employment conditions.

Providing more certainty for long-term funding would also assist in the delivery of the NZ Health Plan.

Simplify flows and reporting

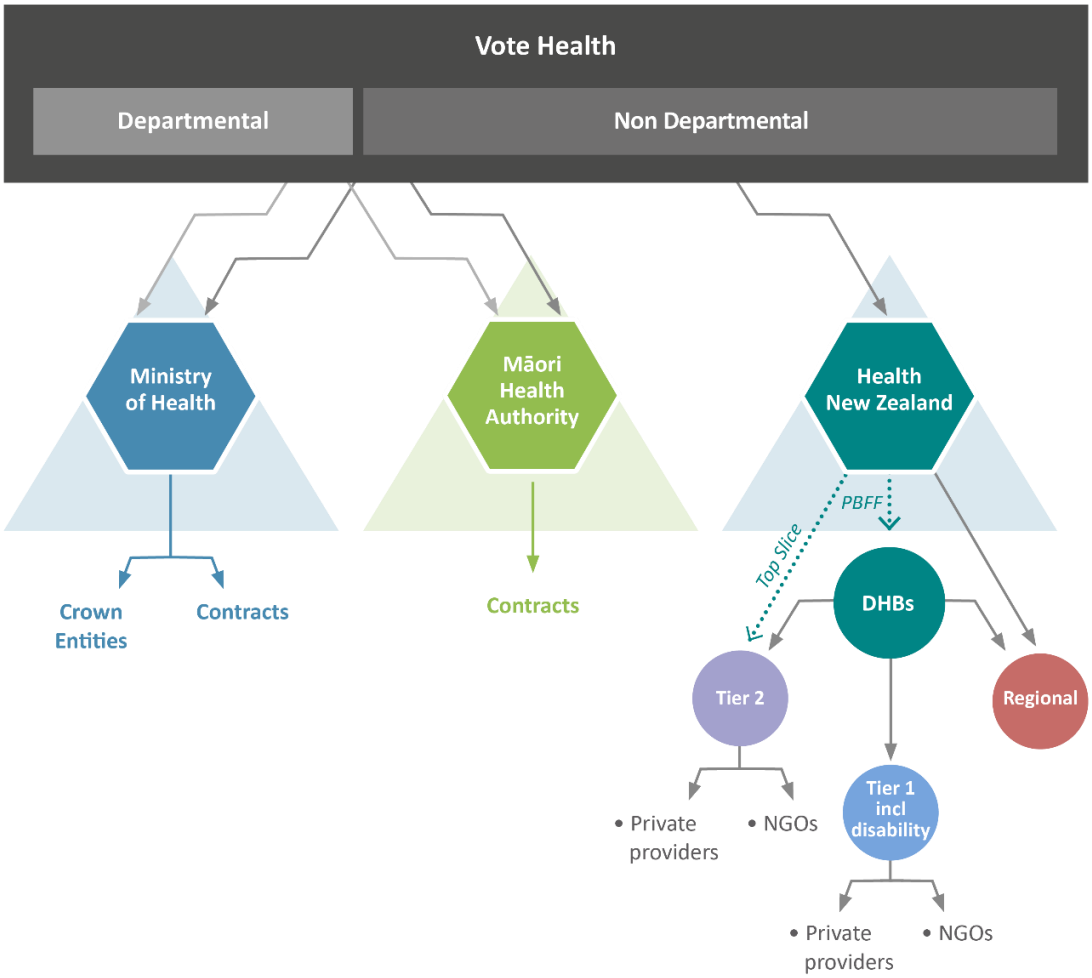
Changing agencies and setting up new ones, would require changes to appropriations (the funding allocations from Government). The Review recommends simplifying the appropriation structure while, at the same time, increasing the level of transparency in financial reporting (refer Figure 4.4).

The Review proposes that having a single combined appropriation for Health NZ and the DHBs would maximise the flexibility of the system while reducing administration. Having separate service-level appropriations creates barriers to integration.

Transparency would be enhanced through increased reporting on funding and expenditure by population group, DHB and service. This would require some technical changes to how the population-based funding formula is managed and how Health NZ and DHB accounts are prepared. Health NZ would be responsible for consistent accounting standards and performance reporting.

The Ministry and the Māori Health Authority would each have two appropriations: a departmental appropriation for the costs of running the organisation and a non-departmental appropriation for purchasing services. There would still be a small number of additional appropriations for other Crown agencies, such as PHARMAC.

Figure 4.4: Diagram of new structure plus new appropriations



Smoothing funding flows to DHBs

Individual DHB revenue is determined in the most part by the population-based funding formula. The Review supports the ongoing use of population-based funding, but is proposing that it should be enhanced in three areas:

- reducing DHB funding flow volatility
- reducing distortions from new initiative funding
- enhancing the methodology and data sources underpinning the formula, particularly for Tier 1

Reducing DHB funding flow volatility

DHBs all raised concerns with the Review about the volatility of funding caused by population forecast revisions. Such recent revisions have resulted in significant funding changes for some DHBs and have often been unpredictable. They have at times arisen from back dated changes in population estimates that have taken a considerable length of time to be determined.

Unpredictable changes in funding are difficult to manage for a health service which is usually a large employer, with staff costs by far its largest expenditure and facing steadily increasing demands.

While the review supports the continued use of a population-based funding formula as the principal means of funding DHBs, it is proposed that more attention is given to devising a formula for smoothing the transition of funding shares arising from population revisions.

Smaller DHBs can also face significant volatility in their expenditure projections as a consequence of being presented with a case that needs highly specialised and/or long-term treatment not routinely provided by the DHB. The funding system handles these costs through inter district flow (IDF) payments. The volatility which arises, particularly for smaller DHBs, could be smoothed by ensuring high cost services are funded nationally and by DHBs entering into longer term fixed revenue arrangements for regional services (further service planning benefits from such arrangements are discussed in the Tier 2 section).

Reducing distortions from new initiative funding

New initiatives funding, which is currently kept in silos for long periods of time, can undermine a population approach to planning and funding. Further, when a new initiative is developed on the basis of a pilot in a few parts of the country, a problem can be created if funding is continued indefinitely, resulting in long term differences in access between DHB populations. A further issue occurs in situations where funding for a pilot stops, but the DHB cannot realistically stop providing the services. If this is the case, there is an additional call on its baseline funding.

The Review considers that when funding is allocated for new initiatives, the timing of the initiative should be specified as ongoing or temporary. Where funding is ongoing, there should be a clear time period of no longer than four years after which it is incorporated into baseline funding.

Enhancing the methodology and data sources underpinning the formula, particularly for Tier 1

The Review recommends that funding to DHBs be allocated using a population-based funding formula. However, the formula should be amended to better reflect the needs of different population groups.

It is acknowledged that this would require an investment in improving health status information. The development process required is outlined below.

- Ensure all DHBs have costing systems in place and comply with costing standards.
- Improve financial accounts and reporting to more accurately and consistently measure how much is spent on what and for whom.
- Develop a nationally consistent collection of Tier 1 services data, including measures of use, quality, outcomes, diagnosis and health status.
- Analyse other social sector data (eg, from the Integrated Data Infrastructure) to better understand the social determinants of health.
- Research differences in access, outcomes and cost of services in rural areas.

While this information is not likely to be available for the next population-based funding formula review, the Review recommends that to move towards a formula with a stronger needs-based approach in the short run, the funding for the Tier 1 components be immediately rebased as discussed in the Tier 1 chapter.

- The Interim Report noted that evidence shows that enhanced Tier 1 services can improve equity and support health and wellbeing for Māori, Pacific peoples and others for whom the current system is not working. The report also outlined data showing a decrease over time in the share of funding for Tier 1 services in New Zealand.

The Review believes that communities need more transparency about how DHBs allocate Tier 1 funding, and how this funding is used to address the needs of communities.

As new funding is applied to enhance Tier 1 services and commissioning is devolved to DHBs, it would be essential that funding was not diverted away from Tier 1 services.

The Review proposes that a ringfence around Tier 1 funding be applied at least for the medium term. It should specify the minimum amount that each DHB would be expected to spend on Tier 1 services. At the locality level, indicative budgets would be published and reported against. This ringfence would provide confidence to the public and to the Government that funding is being used appropriately to develop Tier 1 services.

Improve efficiency and ability to manage within resources

While ensuring long-term stability of revenue would go some way towards assisting with better management of finances, revenue is only part of the problem. Spending continues to rise, due to population growth, an ageing population, inflation and management decisions.

Currently, all 20 DHBs are in deficit, spending more money each year than their budgets. In the long term, significant performance improvements are required to improve the sustainability of the health and disability system. Advances are needed in management and in improving efficiency and service design to create a system that can deliver what New Zealanders need within budget.

Collectively, the range of changes proposed in earlier sections (such as the establishment of Health NZ, a coherent system-wide planning framework and changes to both the number of DHBs and how their DHB boards are constituted) would all contribute to a better performing health and disability system.

Health NZ should also lead changes to back office and support functions where a national approach is more appropriate, and, encourage more consolidation of regional services, in order to reduce overall costs in the system.

Rebalancing the system

Changes in the way funding is managed would not however address the fact that the system would be beginning a new regime in significant deficit. These deficits are unfortunately of a magnitude that they cannot be redressed simply by improved efficiency and better management. The Review therefore proposes that the Government provide additional investment to rebalance the system, but that this be provided through, and managed by Health NZ.

If such funding were simply distributed across all DHBs according to a normal DHB population funding basis it would have limited impact on improving system performance. Similarly, it should not be distributed according to current deficits as this would simply reward poor behaviour and give the system the wrong signal.

Deficits, as a proportion of total revenue, are not evenly distributed across the system. The deficits of approximately half the DHBs could reasonably be attributed to underfunding over the past decade or so. The persistent deficits of others represent a more significant performance problem.

While the review is recommending performance management improvements across the board, the group of DHBs with persistent deficits require more intensive intervention.

The Review therefore proposes that:

- additional funding to rebalance the system should be allocated initially to Health NZ with the bulk of this fund to be allocated proportionally across DHBs' operating expenditure budgets, on a population funding basis, at a level to bring the top half of the DHBs back into a budget-neutral or positive position.
- residual funding would be managed by Health NZ and used to support the interventions required in the other DHBs to address the remaining deficits over time. Once performance issues are addressed, the residual funding would revert to the population funding baseline.

This process would ensure the system as a whole could be kept in balance.

Improve DHB performance

Health NZ should be made accountable for ensuring the health system stays in balance overall, ensuring ongoing financial sustainability. To achieve this Health NZ must be actively monitoring DHBs, coordinating work between them, and requiring actions to address variance in performance.

The Review recommends that Health NZ builds a performance improvement function with the capability to both understand performance variation and offer suitably tailored support.

The intention would be to move beyond the current system of simply publishing performance measures into a system that can analyse performance variance and implement steps to improve performance, working with DHBs including using the experience of high performing DHBs to assist. Such analysis would provide central agencies and the Government with improved understanding of the health and disability system performance and provide more confidence that future funding would translate into more and better services, and outcomes.

Building the future

The Review proposes the following changes

System-level stewardship and leadership is strengthened

- The Ministry of Health should be the chief steward and chief advisor to the Government on health and disability strategy and policy.
- A Māori Health Authority should be established to lead strategic policy with respect to Māori health, to act as kaiarataki for hauora Māori and to ensure the system is committed to achieving equity of outcomes for Māori.
- A new crown entity, Health NZ, should be established to lead delivery of health and disability services across the country. A Charter for Health NZ would be developed that sets out shared values and aims to guide the health workforce culture and behaviours.
- Health NZ should be governed by a board of eight members and a Chair, with 50:50 Crown-Māori representation, with board membership drawn from DHB board members in each of the regions.
- Leadership should be built at all levels of the system, and deliberate actions taken to shape the system culture and capabilities, and provide leaders with the accountabilities, information and tools to lead.

Consumers, whānau and communities are engaged

- Local communities, iwi partners, consumers and whānau, clinical experts and other stakeholders should have meaningful opportunities to influence planning, and be engaged throughout the life of strategic plans to understand priorities, implications for services and outcomes achieved.

District health boards are refocused and accountable

- DHBs should be accountable for both improving the health outcomes and equity among their local populations and contributing to the system's effectiveness.
- All DHBs should be required to operate as a cohesive system subject to Health NZ leadership. Health NZ would oversee a reduction in DHBs from 20 to between eight and 12, and DHB regions to no more than three.
- All DHB Board members should be appointed by the Minister of Health against a transparent set of competencies, including financial and governance experience, tikanga Māori and specific health sector knowledge. The composition of Boards should reflect te Tiriti/the Treaty partnership. DHB Board members should have on-going training and professional development in the capabilities they require to govern effectively.
- DHBs would be expected to engage effectively with Māori, and build their services capacity and capability to engage with, and understand the perspectives of Māori.

- *Continued*

Building the future – continued

The Review proposes the following changes – continued

Integrated planning connects the system

- The New Zealand Health Strategy should set the overall parameters for all planning in the health and disability system.
- A New Zealand Health Outcomes and Services Plan (the NZ Health Plan) should be developed to guide the long-term strategic direction for the system, outcomes to be achieved, and how different parts of the system would work together. The Ministry should have overall responsibility for coordination of the Plan, and lead on system outcome measures. The Māori Health Authority should lead on Māori outcome measures. Health NZ should lead on services planning.
- Each DHB would develop a District Strategic Plan based on the population health needs of its district, include locality arrangements for Tier 1 services, and be guided by the direction and outcomes for the NZ Health Plan. DHBs would also collaborate regionally, and develop regional strategic plans that take a collective view of priorities.

Funding arrangements drive an efficient and effective system

- The predictability of funding for baseline services is maintained through legislation establishing minimum annual increases, determined by a formula reflecting increasing population, needs and costs. Vote Health appropriations should be simplified to support a single integrated system through having a single appropriation for Health NZ and DHBs.
- The transparency of financial reporting should be improved by requiring regular reporting on revenue and expenditure by DHB, population groups and services.
- The stability of individual DHB annual revenue should be improved by smoothing population revision impacts and changes to ways IDFs are managed.
- New initiatives funding should routinely be for a specified term.
- A dedicated performance support function should be established within Health NZ to drive changes in system effectiveness and efficiency.
- Investment aimed at rebalancing the system should be managed through Health NZ to ensure DHBs with unsatisfactory performance, have their access to additional funding more closely supervised.
- The population-based funding formula should be improved to better reflect needs. This would require an investment in improved information across all health care settings as an input to an improved formula.
- Funding for Tier 1 services should be ring-fenced so that it cannot be diverted to other areas.