Implementing the Coalition Agreement on Health

The report of the Steering Group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health

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Dear Ministers

REPORT OF THE STEERING GROUP TO OVERSEE CHANGES TO THE HEALTH AND DISABILITY SECTOR

In response to the terms of reference approved by the Cabinet, this is the report of the Steering Group established by the Minister and Associate Minister of Health to advise them on the policy requirements and implementation issues of the health and disability sector changes included in Section 2 (on changes to public providers) and 3 (on funding arrangements) of the Coalition Agreement on Health.

Our report addresses three key questions in implementing the Government's Coalition Agreement on Health:

- what is the difference between purchasing and funding?
- how does the funder contract with providers for good health and disability outcomes?
- what impact do the answers to these two questions have on the roles and responsibilities of central agencies?

We focus on four fundamental tasks we believe should form the job description of any publicly-funded health and disability sector, regardless of political philosophy, policy parameters or sectoral structures:

- making sure all available resources - funds, people and organisations - are directed to best meeting people's health and disability needs
- making sure processes and information are readily available so groups and individuals can convey their views and preferences to those responsible for managing available resources
- harnessing the collective skills and strengths of those working in the sector by establishing relationships based on shared objectives and supported by a collegial culture
- making sure funding decisions, particularly what can and cannot be funded, are transparent and justifiable.

As you know, the Steering Group’s terms of reference were amended to reflect that the reporting time allowed no opportunity for meaningful consultation. However, the Steering Group did seek specialist input from sector groups and has taken account of their views in discussions leading to this report. We believe the principles underlying this report will be supported by those working in the health and disability services sector.

I would like to record my appreciation of the significant contributions made by my 12 fellow Steering Group members. Their individual dedication and commitment reflected their view that this process was an opportunity to make a difference.
Finally, the Steering Group would like to thank Annette Dixon, convenor of the team of officials assigned to assist the Steering Group, and the individual members of that team, for contributing to this report.

We commend this report for your consideration.

Yours sincerely

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Executive Summary

The Steering Group was set up by the Government as part of its commitment to consult the sector on changes to administration and legislation, governance and reporting. The Steering Group's terms of reference were to advise Health Ministers on policy requirements and implementation of health and disability sector changes in the Coalition Agreement on Health. The Steering Group was particularly asked to report on:

- roles, relationships and accountabilities of sector organisations - funder, providers and central organisations
- future contracting relationships between funder and providers
- timetable for implementation
- necessary legislation
- risk management strategies for implementing changes
- communication and consultation strategies
- fiscal implications of changes.

Themes

The Coalition Agreement announced structural changes for the health and disability sector. These included replacing four purchasers with a single funder and changing the objectives of Crown-owned providers from a profit focus to a need to improve health outcomes. Our report, therefore, does not contain any major new structural initiatives or proposals over and above those announced in the Coalition Agreement. It does have five key themes providing a framework for the initiatives it details.

- Long term focus
  The health and disability sector must revolve around a common, strategic vision, sustainable over the longer term. This vision should be to improve the health and independence of New Zealanders. The change process should minimise disruption. Future strategic change should be evolutionary to capture gains and avoid the costs, disruption and uncertainty created by major structural change.

- Constructive relationships
  Relationships between people and organisations should be more collaborative and co-operative at all levels. Participation of individuals, communities, health professionals and organisations should be sought and encouraged. Contracts will continue to be central to the way the funder and providers conduct their affairs, but should be based on aligned objectives and good relationships.

- Outcome focus
  Services should always be focused on outcome, although it is also important to acknowledge that health status is influenced by factors beyond the health sector's control. Co-ordination will improve services and help users improve their own health and independence.
Inevitable tensions and the need for openness

Health and disability systems around the world inevitably face the tension between limited funds and unlimited demand. Rationing is inevitable. We believe it is better to be open and clear about the need to ration. Decision-makers at all levels must be accountable and must disclose the information necessary for communities to have confidence that rationing is not only fair, but is seen to be fair. That same transparency will encourage good performance.

Treaty of Waitangi obligations

As well as continuing to address disparities in health status between Māori and non-Māori, the health and disability sector must also recognise obligations under the Treaty of Waitangi. Positive Māori development is a key issue. In the health and disability sector, this will include increased attention to encouraging development of Māori providers and workforce, and delivery of mainstream health and disability services culturally appropriate to Māori.

Roles

The **funder’s role** is to improve health outcomes and the population’s health status by funding health and disability support services, and focusing on getting the best health outcomes from available resources. The funder’s functions include:

- determining current and future health care needs
- setting priorities within available funding
- developing operational policy
- contributing to strategic policy developed by the Ministry of Health
- developing, negotiating and managing contracts with providers
- monitoring the performance of providers against contract.

The **role of all providers** is:

- providing health and disability services to individuals and populations according to funding contracts
- taking responsibility for service quality
- contributing to the work of the funder as it makes allocation decisions
- becoming more involved with the funder, other providers and communities in planning and providing care packages and other kinds of service arrangements.

In addition, the **role of Crown-owned providers** is providing health and disability services which enhance health and disability status by improving service quality, levels or costs, as agreed with the funder. Also, to do this in a way which ensures effective use of resources. Crown-owned providers must be businesslike which involves:

- maximising value by continuously improving productivity
- sound financial management
- consumer-focused services.
Some Crown Health Enterprises (CHEs) do not provide the full range of services outlined in the Coalition Agreement on Health. We believe it would be a backward step to require CHEs to work towards doing so, especially where services are satisfactorily delivered by other providers.

The role of the Ministry of Health is to have an overview of the sector's performance, as well as acknowledging non-health factors contributing to health status, such as housing, education and employment issues. The Ministry of Health should lead the health and disability sector by:

- developing strategic policy advice for improving New Zealanders' health and independence status
- establishing and promoting links with other sectors
- monitoring funder performance
- advising Ministers
- regulating the health and disability sector.

The role of the National Health Committee (NHC) should continue to be advising the Minister of Health on clinical and cost effectiveness of interventions for improving health status. It has a significant role in promoting dialogue on fair rationing. It should stay independent of the funder but consult with it, particularly about the funder's ability to implement NHC advice within its budget. The NHC should continue to be serviced by the Ministry.

Crown-owned providers should be better co-ordinated. The Government should consider the options for co-ordination, but in the meantime the Crown Company Monitoring Advisory Unit (CCMAU) should continue to monitor Crown-owned providers' financial and non-financial performance against their Statements of Intent.

The Treasury should continue to monitor and advise on the financial performance and effectiveness of Crown-owned agencies.

The Mental Health Commission should continue to monitor and advise the Minister of Health on health organisations' implementation of the national mental health strategy.

Te Puni Kōkiri (TPK) should continue to monitor the Ministry on its delivery of strategic policy advice on Māori health, and provide policy advice on the relationship between Māori health, Māori development and the development of Māori health providers. It will also be responsible for establishing a Māori Health Promotion Unit.

The role of the New Zealand Health Information Service (NZHIS) is developing the infrastructure to promote use of better information for health sector decision-making. It is now part of the Ministry, but we believe it could exist independently.

Residual Health Management Unit (RHMU) roles and responsibilities should be reviewed by the Government in the light of any review of the capital structure of Crown-owned providers.

All public agencies are subject to scrutiny by the Ombudsman and the Office of the Auditor-General.

We consider little progress will be made in the sector unless all organisations commit themselves to constructive, long term relationships.
The funder will have key relationships with:

- **the Minister of Health**: this is the funder’s primary relationship - the funder is the Minister’s agent and responsible to the Minister for funding services
- **health and disability service providers**: this focuses on a move from ‘purchasing’ to ‘funding’, and on relational contracting for better health and independence outcomes. We believe the funder, in this new environment, should develop the most appropriate contract forms and relationships with the best providers to meet the population’s health and disability needs (while staying within the Coalition Agreement guidelines)
- **Ministry of Health**: we expect the funder to contribute significantly to Ministry advice to the Minister of Health on strategic initiatives and priorities to improve health status
- **government agencies in other sectors**: the Government must strengthen its intersectoral approach to improve health status. This will require joint planning by the funder and other government agencies
- **ACC**: the funder should work closely with ACC to meet the Government’s objectives for the sector, to reduce costs by sharing resources where possible and resolving any differences
- **the public**: the funder must consult to determine service priorities and evaluate costs and benefits of new programmes. It should develop positive relationships with communities.

Key relationships for all providers are with:

- **service users**: providing responsive, quality services
- **the funder and other providers**: working together to provide seamless care and disability support services for individuals and families
- **communities**: giving and receiving feedback about service response to individual and community need.

Additional key relationships for Crown-owned providers are with:

- **the funder, other providers and communities**: emphasising relational contracting to lessen tension between funder and providers. This would yield more co-operation with other providers, including Māori providers, in the provision of seamless care. Secrecy amongst Crown-owned providers is unnecessary - they will not be in competition. ‘Commercial sensitivity’ is unlikely to be an acceptable reason for lack of co-operation with other Crown-owned providers
- **health professionals**: Crown-owned provider culture must change if relationships are to improve. De-emphasising profit should help in this. Crown-owned providers should involve health professionals in management, contracting, planning and day-to-day service management.
Accountabilities

Key sector accountabilities are:

- the funder to be accountable to Parliament, via the Minister of Health, for its performance against its Statement of Intent, and responsible to the Minister for its performance in meeting the Minister’s key expectations and objectives

- all providers to be accountable to the funder for fulfilling its contract and for quality assurance, and to individuals for service quality

- Crown-owned providers to be accountable to the funder for performance against contract, and to Parliament through shareholding Ministers (the Ministers of Health and Finance) for performance against their Statements of Intent.

We recommend the funder be a Crown-owned Entity for reasons of transparency and accountability. Ministers should appoint directors with relevant skills.

In our view, the best organisational model for a Crown-owned provider is the not-for-profit company required to cover its costs, including that of capital, over time. The cost of capital should be funded. Crown-owned providers should be better co-ordinated, particularly in the areas of capital investment, monitoring and service reconfiguration. The Government should consider options for greater co-ordination. While options are being evaluated, CCMAU should continue to monitor financial and non-financial performance of Crown-owned providers against their Statements of Intent, because good monitoring and strong accountability are important regardless of not-for-profit status.

We endorse the Coalition Agreement’s requirement that Crown-owned providers report directly to the Minister of Health. We note this has already been effected by the Government in combining Health and Crown Health Enterprises portfolios. We do not consider changes should be made to current accountability arrangements between Crown-owned providers and the Government. That is, they should continue to be directly accountable to the Minister of Health.

A new approach to disability support services

Changes are needed to ensure disability support services better meet the needs of consumers, and realise efficiency gains. Services must be more flexible, consumers should be empowered, and there should be better links between services.

Building on gains for Māori

Māori health still lags behind non-Māori in most health status indicators and must remain a priority area for improvement. The gains made in Māori health development should be consolidated and the trend towards Māori participation in the health sector speeded up. The sector should also continue to acknowledge the special relationship between Māori and the Crown under the Treaty of Waitangi.

Participating in health

Increased participation in the sector is important. Communities have the right to participate, and funder and providers are responsible for ensuring communities’ values and preferences are reflected in decision-making. This means disclosing and communicating information and recognising the value of affirmative action in encouraging participation.
Implementing the changes

Three elements key to implementing the changes signalled in this report are:

- **consultation and communication** - the sector anticipates this report being made widely available. We suggest it be released, after initial consideration by the Ministers, who will determine the nature and extent of further consultation. However, we draw to the Government's attention to the fact that the timetable for introducing legislation limits opportunity for meaningful consultation. Whatever the Government decides, it should be transparent about whether or not it is consulting people on change or informing them of changes already decided.

- **the timetable leading up to legislation** - work that should be immediately done by officials includes the ownership structure for Crown-owned providers and regulations for information disclosure. If the Government wishes to meet the timetable set out in the Coalition Agreement for the new organisations to be established by July 1998, policy decisions with legislative implications must be made by the beginning of August 1997 to allow a Health and Disability Amendment Bill to be introduced by the end of September 1997.

- **risks** - as well as particular risks discussed in each chapter, we note general risks of changes proposed in this report. These include:
  - impact of non-health sector policies
  - acceptance by a sector suffering reform fatigue
  - funder performance and behaviour
  - cynicism about participation
  - perverse policy incentives
  - uncontrolled sector costs

- **risk management** - the proposals in this report, taken together, are key mechanisms for addressing these risks. They are necessary but not, however, sufficient: improving sector performance depends on Government realism about funding, and Government, sector and community acceptance of what services that can be delivered.

- **fiscal implications** - the changes outlined in this report can be made without increasing overall bureaucracy, but there may be some associated transition costs. Whether the sector can efficiently manage resources within its capped budget remains a fiscal risk. It is essential the Government maintains momentum in dealing simultaneously with overall funding levels and funding path, removing CHE deficits and changing capital structures.
CHAPTER 1

Introduction

This Steering Group was set up by the Government as part of its commitment under the Coalition Agreement to consult the sector on changes to administration and legislation, governance and reporting. The Steering Group's role was to advise on implementing Sections 2 and 3 of the Coalition Agreement's policies on health.

Reports of this kind tend to be impersonal. However, we are acutely aware that health and disability services are about people - their problems and pain, and their hope that better health and independence will let them participate in and contribute to the social and economic well-being of their families, whānau and their communities, and New Zealand society.

We believe New Zealanders want a health system that:

- provides security of access to quality care
- delivers effective care for the money governments provide
- provides modern care responsive to individual and community needs
- ensures accountability throughout the system from the service user to the Minister
- is supported by efficient bureaucracies
- ensures performance is monitored against known requirements
- focuses on a long term vision for improving the health and independence of New Zealanders.

From an individual's perspective, this is the need to know they will be cared for when they need it, at an affordable cost. From a policy perspective, it is addressed by:

- ensuring the sector can sustain itself on the public funding it receives
- contracting which facilitates access to care by those in need
- for some services, public ownership of facilities to ensure security of access.

This answers the individual's need to know they will be well looked after, but also implies that government agencies funding and providing care do the best they can with the money available. It requires that:

- governments be clear about their agencies' roles and responsibilities
- decisions about who gets what care are transparent and based on evidence of effectiveness
- all parts of the system operate as efficiently as possible
- there is acknowledgement that limited funds will not yield unlimited amounts of care. This means fair rationing of services
- the health system focuses on people's health, acknowledging factors outside the health and disability sector.
Modern care that is responsive to needs

For the individual, this means getting quality care appropriate to individual and cultural needs. It means services which treat people with dignity and respect, enable them to influence their own treatment, support them in their efforts to keep themselves well and provide a co-ordinated, seamless service. It also means individuals participating in improving their own health and independence. For the sector, it means focusing on quality as well as efficiency of care. It also means greater involvement by providers in working with the funder to improve health gains for their communities and provide disability services that maximise independence.

Accountability throughout the system from service user to the Minister

All the way through the system, people and organisations should be accountable for their actions. This means:

- clarity of roles between agencies
- transparency of processes and decisions
- inclusion of communities' values and preferences in decision-making at all levels.

Efficient bureaucracies

From the individual perspective, this means being served by agencies focused on the public interest rather than on administrative convenience. Fair rationing and effectiveness require every dollar to deliver as much health care as possible. From the agency's perspective, it means adding value at every step so bureaucracy is kept to a minimum.

Monitoring performance

For the individual, this means being able to assess the performance of each agency (including the government of the day). For all sector agencies, it means:

- setting relevant performance objectives
- measuring performance against those objectives
- disclosing information that allows judgement of performance
- changing behaviour to improve performance
- developing health measures to reflect outcomes and desired gains.

A long term vision

We believe these needs add up to New Zealanders' long term vision for their publicly-funded health and disability system - to improve the health and independence of New Zealanders.

Making it work

The Coalition Agreement affirms the basic funder/provider split, and we recommend no change to that. It is clear some processes, values and relationships underpinning those structures need to change, and that will partly be a result of modifying agency responsibilities and accountabilities. This is signalled in the Coalition Agreement: 'The Coalition Partners are committed to publicly-funded health care that encourages cooperation and collaboration...'

Our starting point is one funder. We expect this to reduce administration costs and replication of effort, and improve contracting by drawing on best practice. A single funder should improve national consistency of quality and access, but still respond to

1 By 'agencies', we refer throughout this report specifically to government agencies, such as the funder, Crown-owned providers, the Ministry of Health and other central bodies.
local needs, values and priorities. In particular, we expect communities, health professionals and providers to be more involved in the funder's decision-making. Funder culture and behaviour must focus on responding to these values.

Crown-owned providers will no longer have to make a profit, but they will be expected to operate in a businesslike fashion, as stated in the Coalition Agreement. Among other things, this means focusing on the quality and effectiveness, as well as the efficiency, of care.

The way funder and providers work together must be addressed. Contracting will generally:

- focus on desired health gains, as well as efficient service delivery
- be longer term for more certainty and reduction of transaction costs
- include incentives promoting service quality and provider performance
- require accountability for use of public funds.

But we need to be realistic: contracting is where unlimited health and disability needs and finite resources intersect. There will always be tension but it can be better managed. This will require a credible level of resources, the ability to change services, and changes to funder and provider cultures.

Monitoring and accountability of funder and providers will:

- be based on measurable objectives
- be relevant to organisations' objectives
- focus where possible on contribution to health gain as well as financial performance
- respect organisations' roles so they have a mandate to do their job.

Planning to meet the needs of the population will change, as the funder will be expected to:

- take account of community values and preferences in its decision-making
- involve health professionals and providers in service development
- co-ordinate services across the spectrum of care
- devolve decision-making when appropriate, ie to those with the best information and incentives.

These changes refine the existing structure's roles and relationships. In implementing a single funder and by removing the profit focus of Crown-owned providers, we are looking for a change in emphasis rather than a total system redesign. The Coalition Agreement signals a general policy direction that every effort be made to minimise disruption to the sector. So we seek an evolutionary approach to change. If this report can help answer questions we believe concern all New Zealanders, we will be satisfied we have:

- interpreted the spirit of the Coalition Agreement on Health
- met the terms of reference set by the Ministers
- made a worthwhile contribution to a publicly-funded health sector in which all participants - governments, central agencies, health managers, health professionals, communities and individuals - work together in the interests of those needing quality health and disability support services.
The Coalition Agreement states 'the Government is committed to providing a flexible, modern, properly funded, accessible health service that meets changing public needs and expectations'. This report is intended to assist the Government in its commitment.

**Structure of the report**

*Chapter 2* looks at the context in which change is to take place.

*Chapter 3* examines the role of contracting as the basis of the relationship between the funder and providers and between the funder and communities whose needs it is charged with meeting.

*Chapter 4* looks at the role, relationships and accountabilities of the funder.

*Chapter 5* looks at the role, relationships and accountabilities of health and disability providers.

*Chapter 6* is about the role, relationships and accountabilities of the central agencies.

*Chapter 7* looks at disability support services.

*Chapter 8* looks at the specific needs of Māori.

*Chapter 9* examines the value of community participation in health.

*Chapter 10* focuses on issues to do with implementing this report's recommendations, including the need for a change management strategy, likely amendments to legislation, and the fiscal implications of the changes.
CHAPTER 2

The Context for Change

Terms of reference

Our task is to advise Health Ministers on policy requirements and implementation issues of the health and disability sector changes included in section 2 (on changes to public providers) and 3 (on funding arrangements) of the Coalition Agreement on Health.

Specifically, this includes advice on:

- roles, relationships and accountability arrangements for health and disability sector agencies
- future contracting arrangements between funder and providers
- the implementation timetable
- the legislation required to implement changes
- risk management strategies to be adopted in making the changes
- communications and consultation strategies
- fiscal implications of changes.

The full terms of reference are attached as Appendix 2.

We address policy requirements and implementation issues in the chapters that follow. We are also aware of some additional strategies we think necessary to address problems the Coalition Agreement wants resolved.

Health and disability needs, expectations and resourcing

A major problem facing the New Zealand health and disability system is a lack of clarity on how funding levels relate to service expectations. As a result, how resourcing ties in with health and independence needs, what level of service funding is expected to buy, and what services taxpayers can expect from their tax dollars, have never been adequately resolved. In a health and disability system like New Zealand's, with governments meeting most of the cost of health and disability services on behalf of taxpayers, demand for service at an individual level will always be greater than the public purse can provide. Making the most of available resources will always mean making hard choices about what services will be funded and which health and independence needs will be met. The key issue is how to do this in a way which has credibility, legitimacy and integrity, and where possible, more clarity.

Failing to do this has made the current system subject to irreconcilable tensions and constraints. Public expenditure on health has, at best, been fairly constant in real per capita terms\(^2\) (refer to figure 1)\(^3\), while at the same time expectations about what the health and disability system can deliver have risen. Cost growth in major providers is

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\(^2\) Vote:Health grew strongly from the mid-1980s and peaked in 1988/89. From 1988/89 to 1992/93 this trend was reversed with a drop of 16% in real per capita funding. Since 1993/94 funding has increased, but real per capita funding through Vote:Health in 1996/97 is 10% below that in 1988/89. Refer Ministry of Health: Sustainable Funding Package for the Health and Disability Sector (1996).

\(^3\) Public expenditure here includes government expenditure on health and disability support services through Vote:Health, ACC and other government agencies, plus expenditure on health services by local government authorities. It excludes capital contributions and excludes transfers from other votes to Vote:Health for non-health items. Refer Ministry of Health: Health Expenditure Trends in New Zealand 1980 - 1996 (1997).
another important factor. These expectations have partly been fuelled by advances in medical technology, making it possible to do more things for more people. They have also been partly due to reluctance to accept the need for rationing and the desire for a system that could do everything for everybody.

The 1991 health reforms (implemented in 1993) brought in the purchaser/provider split, established four Regional Health Authorities and brought disability support services into the purchasing framework. The success of each RHA depended on its:

- ability to develop and use good information on health needs and priorities
- incentives to perform in ways that met the Government expectations
- ability to learn as an organisation, which in turn required freedom to innovate
- autonomy to make rationing decisions about services, and shift resources to areas of greatest need.

Patterns of service delivery - what services to buy, where from and how much - tend to be inherently rigid. The pattern of demand for some services is not easily controlled by purchasers. Moreover, requirements for public consultation can make changing patterns of service delivery a difficult and protracted process. Change has often been possible only at the margin, and RHAs have found it difficult to re-allocate funding within fixed budgets to meet emerging needs or changing priorities.

Instead, particular pressures have often been met by ad hoc funding adjustments. These have been tagged to the purchase of specified additional services. Ad hoc adjustments made up more than 11% of Vote:Health for 1996/97. Ad hoc increases bring ad hoc responses and make service planning difficult. Using tagged funds to meet specific service objectives undermined RHAs' role and accountability for resource allocation and, together with ring-fences for DSS and public health, further constrained the RHAs' ability to manage budgets and make trade-offs between services.

People often use the media and political avenues to obtain services. This is a legitimate use of the democratic process but it can lead to further ad hoc decision-making, which may compromise the fair allocation of resources.
The tension between service expectations and funding levels was aggravated by unrealistic expectations of productivity gains achievable in the public hospital sector. Services delivered through the public hospital system account for $2.8 billion of the $5.5 billion spent annually on health and disability services, and the efficiency and effectiveness of public hospitals has a major impact on how well the health system meets public expectations.

Crown Health Enterprises (CHEs) began life in 1993 with aggregate deficits of $240 million (a gap of about 10% between revenue and costs) and an expectation that productivity improvements would enable CHEs to offset inflation, break even within three years and move to earning normal returns on equity over time. But despite revenue increases of more than $200 million since 1993/94, costs increased by $267 million over the same period. Costs (particularly staff costs) have increased ahead of inflation, with total cost increases of some 10% between 1993/94 and 1995/96. Refer to figure 2.

Figure 2: Actual CHE Revenue and Costs
1993/94 to 1996/97 (Year Ending June)

The limited efficiency gains tended to be made by increasing services rather than by lowering total costs. Total patient discharges increased 9% over the same period. However, such improvements have done little to meet public anxiety about access to services.

The CHE deficit remains at about the same level despite optimistic CHE business plans and additional funding. Refer to figure 3.

Figure 3: Actual and Projected Financial Performance of CHEs (Year Ending June)

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4 CCMAU: Crown Health Enterprises: Briefing to the Incoming Minister (1996)
5 adjusted for case mix and inpatient/day patient.
Three components of the deficits are:

- over-production of service levels above contracts, some wanted by RHAs, but others representing poor service management by CHEs
- poor cost control by CHEs
- under-pricing by RHAs.

The persistence of CHE deficits is probably due to a combination of several factors:

- in hindsight, the level of efficiency gains achievable within public hospitals, and the time needed to make them were over-optimistic
- political discomfort with the changes sometimes needed for efficiency gains, and the lack of a satisfactory way to avoid bailing out an insolvent CHE, may have weakened accountability and incentives for performance, contributing to ongoing CHE cost growth
- CHE deficits have been an easy way to meet funding and service pressures.

The persistence of deficits meant CHEs, RHAs and shareholders focused strongly on financial performance. Despite this focus, poor financial performance against expectations has:

- exacerbated tensions between management and health professionals
- created conflicting RHA and CHE objectives, generated destructive tensions in contract negotiations, and reduced incentives and opportunities for RHAs to set up better purchasing arrangements and innovative programmes
- given credence to anti-reform views, and raised public and sector concern that the system is not working well.

In short, the confidence of the public, politicians, and those who work in the sector, in the integrity of the system and its ability to deliver services efficiently, effectively and fairly has been eroded by:

- constraints on RHAs which are, therefore, unable to meet rising service expectations
- unrealistic efficiency and profit expectations of CHEs
- ad hoc funding increases in response to particular service pressures
- political involvement in individual rationing decisions
- the need for additional financial support to ailing public hospitals
- fear of lack of access, and concerns about service quality.

These have contributed to poor relationships, poor accountability and a culture of blame.
The Coalition Agreement states that government funding should remain separate from service delivery, and be managed by contractual relationships. We endorse this position. Some real gains have been achieved by it. They include:

- improved health needs information on which to base allocative decisions, including better information on what services are being provided, and better understanding of relative costs and benefits of services
- greater focus on needs assessment in shaping purchase decisions, greater emphasis on planning for populations, and greater reliance on evidence of effectiveness in purchase decisions
- greater attention to primary care and preventive health
- greater role clarity, permitting greater organisational focus and performance accountability
- addressing long-standing inequities of access between population groups (for example, in Māori health, and between regions)
- more Māori participation in service delivery and purchasing decisions
- new arrangements for primary care funding
- emergence of new providers and innovations in service delivery.

We think it important to keep sight of these gains, and build on them. However, there are features of health services in general, and the New Zealand system in particular, which make contracting for services difficult and have probably hampered the development of effective contractual relationships. In particular:

- health care is highly complex, with major uncertainty about what individual health needs are and what interventions would best address them. People do not have neatly pigeon-holed problems or health and independence needs. Detailed contracting for the provision of services can be difficult, and decisions about what services are appropriate under what circumstances often need to be taken at the clinical level when the service is delivered, rather than being specified in advance. Over-reliance on the letter of the contract can lead to fragmentation, disruption and poor co-ordination of service delivery to the client
- often either RHAs or providers will be committed to different stakeholders (such as the need to maintain service continuity to existing clients or service users, or the need to respond to government policies, priorities or objectives). These commitments reduce the options open to parties and make it difficult to negotiate satisfactorily
- RHAs have been the dominant, if not the only, purchaser of most services. This has meant RHAs have often had the stronger bargaining position in contract negotiations. Neither have RHAs been as pressed by time or financial considerations to close contracts. On the other hand, providers have sometimes not had a good understanding of their costs, or even the services they are providing, as a basis for contracting
- the political nature of publicly-funded health and disability services means it has been easier for contracting parties to resort to public negotiation (through, for example, battles in the media over pricing and services) or seek Ministerial or central agency involvement in contract disputes, rather than resolving difficulties together.
the financial environment where there has been a wide gap between RHA revenue to CHEs and CHE costs, has also made contracting relationships difficult.

A further set of problems also underpins CHE relationships:

- CHEs have a monopoly on acute secondary and tertiary services. So contestability of service provision for CHE-based services has existed only at the margin and, for most CHE services, the relationship between CHE and RHA is a bilateral monopoly (that is, a single customer and a single supplier). Misperceptions of what constitutes sound 'commercial' behaviour have probably contributed to adversarial relationships, a culture of secrecy, and poorer planning and service decisions on both sides. As a result, the outcome of contract negotiations can be unpredictable, and influenced by interpersonal relationships and styles.

- both RHAs and CHEs are owned by the Government, and in effect, backed by an implicit government 'guarantee'. This affects negotiating positions and incentives to finalise contracts.

- RHAs and CHEs have had conflicting objectives, incentives and cultures. CHEs have been pressured to be more efficient to lower total costs and improve bottom line performance. RHAs want these gains reflected in lower service prices, better quality, or greater volumes. This has made it difficult to develop longer term working relationships where both parties could share the gains of better performance, and led to protracted negotiations.

As a result:

- in general only limited progress has been made in developing effective relationships between purchasers and providers

- those working in the sector and controlling resources through day-to-day decisions have failed to see the relevance of some processes and agencies

- the confidence of the public, the Government, and some working in the sector, in the system's ability to meet the health and disability needs of New Zealanders has diminished.

These concerns appear to underpin the Coalition Agreement on Health.

Our recommendations for the future

Our recommendations will go some way to restoring confidence and improving sector relationships, and thus, contribute to the effective functioning of the public health and disability system, through:

- better strategic co-ordination at all levels: within Government, between central agencies, across sectors, between funder and providers, and among providers

- building on sector evaluation and experience and the gains achieved to date in developing better management practice, new and better approaches to contracting, and ways to involve health professionals and communities

- accelerating gains in Māori health and independence through the current structures

- developing more effective and constructive working relationships, based on shared goals and more available information

- clarifying the roles, relationships and accountabilities of all sector parties

- moving towards focusing on relevant health and independence improvements.
However, taxpayers must be clear what they can expect the system to cost and what, as service users, they can expect it to deliver. This is a problem which, in one form or another, all health and disability systems face, and all address in different ways. It is not one that more money alone can fix; several strategies are needed. As well as a more credible funding path there should be a process that better aligns needs, expectations and resourcing. The key is in greater understanding and consistent signals, at all levels in the system, about what services can be expected from the health and disability system, and what services can be provided within the available resources.

This issue falls outside our terms of reference. But the thrust of the Coalition Agreement, and the changes in roles, relationships, and accountabilities we have considered, may be of limited benefit unless this fundamental problem is addressed.
CHAPTER 3
Funding for Better Health and Independence Outcomes

This chapter discusses two key questions the Steering Group was asked to consider:

- what is involved in moving from 'purchasing' to 'funding'?
- what can we learn about contracting that will yield better health and independence outcomes?

Funding rather than purchasing

We see a funding environment as characterised by:

- a focus on desired health and independence outcomes and service effectiveness and quality as well as efficient delivery, as an integral part of funding contracts. But we would not support a wholesale move to contracting exclusively for health and independence outcomes because these are influenced by factors beyond the control of the health and disability sector
- greater emphasis on contracting for the delivery of co-ordinated service packages, from the best provider or group of providers, to meet the health and disability needs of individuals and communities
- evolution of relationships and contract forms the funder and providers must develop given the services and realities of the contracting environment. ‘Relational contracting’ will be particularly important for services whose contestability is limited, or where service requirements are unclear.

We believe the funder should develop the most appropriate contract forms and relationships with providers that best meet its requirements. Given the sector's diversity, complexity and dynamic nature the hinder should develop a variety of approaches which lead to value-for-money funding decisions, and the best health and independence outcomes for individuals or communities.

Contracting and health and independence outcomes

Ultimately, the funder wants to improve health and independence outcomes by ensuring access to high quality services. This means deciding which are the most cost effective and appropriate interventions, and at what point in the care continuum to best meet people's health and disability support needs.

Those with the best information and incentives should decide what care is appropriate and when. We believe such decisions should be delegated when possible, and where doing so is likely to mean better value, consistent with accountability for the best use of resources.

In short to medium term practice, understanding of and techniques for assessing outcomes may not be well developed enough to be a good basis for accountability. Contracting exclusively for health and independence outcomes may be difficult given that:

- health and independence outcomes are influenced by many things other than 'health care', making it difficult to hold the provider accountable for achieving them
- comprehensive measures of relevant outcomes have yet to be internationally developed
• the time between service provision and resulting outcomes may be long, again making meaningful accountability difficult

• Government and public expectations demand the funder ensures security of access and efficiency etc.

The funder should contract directly with providers for achieving certain health and independence outcomes where suitable measures are available, the outcomes are well under the provider's control and such contracts are likely to lead to better decision-making and performance than other options. In the short term, however, it is likely contracts will continue to be for the delivery of specified services.

Nevertheless, a clear shared understanding of desired outcomes is important to the development of effective contracts. To make the best contribution to health outcomes and ensure value for money, contracts for service delivery should cover the quality and effectiveness of services as part of contract development, specification and monitoring, and reward.

Co-ordination and integration of service delivery

From the individual's perspective, the best contracting arrangements are those which provide seamless care, from prevention to treatment to support and palliative care. This means successfully co-ordinating and integrating services across a range of providers and contexts.

'Integrated care' is one of several terms used to describe approaches aimed at improving care co-ordination and sector performance. It is one of the most promising developments in contracting here and overseas in terms of co-ordination, improved cost effectiveness of treatment choices and better health and independence outcomes. A provider (or group of providers) is responsible for ensuring a defined group of people under its care gets a co-ordinated set of services appropriate to its needs. Within this broad definition, approaches vary in the degree to which responsibility for purchase decisions is devolved, and the extent to which risk and gains are shared.

There has been much debate on the relative merits of integrated care. The literature - here and internationally - advises which approaches have worked in which circumstances, but also warns against wholesale application of any one model. The focus must be on funder and providers working together to develop approaches best suiting each situation.

Integrated care is one contracting approach available to the funder, and should only be pursued where it will enhance health and independence outcomes, through better co-ordination and more cost effective service provision. Clearly, the benefits of such an approach should be weighed against any additional costs and risks. Key risks to be addressed by the funder in considering integrated care approaches include:

• 'cream skimming' (organisations accepting only healthy people with cheaper health needs)

• cost shifting

• under-servicing or cutting corners in the quality of care

• determining a reasonable budget for the services to be provided.

The regulatory and contracting environment needs to be further developed to manage these risks.
The nature of the relationship will depend on what service is to be supplied under the contract, and what the funding environment is like. Given the range and complexity of health and disability support services, the funder must embrace a diversity of contract forms and contractual relationships to effectively promote health and independence. For some services where contracting has been more difficult, we expect funder and providers to emphasise relational contracting, developing types of relationships needed to work in such an environment. For other services, where contracting is relatively straightforward, we expect ‘funding’ to look little different from current ‘purchasing’.

In the past, relationships have been influenced by those in key positions. It is critical to attract and retain good performers. Another critical factor in the relationship between CHEs and RHAs has been financial problems. Where there have been wide gaps between revenue offered and CHE costs, relationships have been strained.

Contracting has been more difficult where:

- services to be provided were unclear, or demand was uncertain, making it difficult to be explicit about what is expected. In the future, where a contract cannot cover all contingencies, or an overly legalistic interpretation might damage the integrity of the service, the two parties need to put priority on developing relationships to sustain them through uncertainty

- there was only one supplier of services in an area (particularly for CHE-based services), making it difficult to determine a reasonable price for them or ensure performance. More reliance is called for on disclosure of performance against quality and efficiency benchmarks in the absence of sound market information

- either purchasers or providers were committed to other stakeholders, reducing their options and making it difficult to negotiate satisfactorily. For example, providers’ commitments to service users, the Government or the owner may impact on what they want out of negotiations. Ideally, these commitments, objectives and priorities should be shared and understood by both parties, and approached jointly to ensure they are met.

The key to a good relationship is confidence in the other party, based on a history of consistency and integrity in mutual dealings and a sense of a shared future. We consider confidence develops through:

- **trust**: where contracts cannot be quite specific, or where performance is hard to assess, the relationship must be based to some extent on trust

- **acceptance of mutual interdependence**: parties each have an interest in sustaining the relationship, and therefore in each other’s ongoing viability

- **shared goals**: being clear about where goals align and where they diverge, and constructing the contract around these to as far as possible align incentives so parties can meet both individual and shared goals

- **information sharing**: where contestability is limited, information sharing will be more important. Determining reasonable prices for services will rely on developing a sound base of comparative clinical and financial performance information, and deep dialogue and understanding of each other’s objectives, business requirements and cost structure, as well as what practical improvements are possible and desirable. This could include joint planning of service needs, investment, business planning etc.

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6 To be effective in a bilateral monopoly situation, where there is only one buyer and one seller, contracting has to be treated as if solving a problem internal to a single organisation: efficient outcome of negotiations would be the same as if the two parties were a part of the same organisation (so-called ‘virtual’ integration). This means sharing appropriate information, joint planning, and ensuring decisions are based on the resource cost of production rather than a negotiated ‘price’.
- **good faith in negotiations**: parties should agree about and commit themselves to the negotiation process. This includes agreeing principles by which to judge parties' performance in negotiation, and incentives for them to stick to that process.

- **ability to negotiate changes**: parties should agree on processes to renegotiate the contract in case of contingencies, where it is not practical or desirable to specify all requirements or anticipate all contingencies.

- **mechanisms for conflict resolution**: parties need mechanisms to help manage their ongoing dealings and handle disputes. This may include an agreed process (such as mediation or arbitration) whose outcome is accepted as fair by both parties.

- **continuity**: confidence and trust develop gradually through shared experiences.

Beyond these general principles, we are reluctant to suggest a prescriptive approach to contracting because:

- the funder and providers are better placed than the centre to determine the most appropriate contract approach in particular circumstances.

- prescribing contract approaches may stifle innovation by funder and providers, and make it more difficult to respond to changing circumstances and evolving knowledge and technology.

- limiting funder actions may make it more difficult to hold it accountable for its performance.

The funder needs to be able to buy the most appropriate services from the most appropriate provider to make best use of resources. This means having a choice of providers, and choosing the most appropriate for each situation. We note that the Government has issued guidelines to RHAs operationalising provisions under section 2 d (ii) of the Coalition Agreement. We expect these guidelines to extend to the funder.

We particularly note the role of the 'third sector', made up of providers neither publicly nor privately-owned. It includes voluntary or not-for-profit agencies, community-owned and Māori providers. The size of the contribution varies across the country. Contracting with the third sector gives the funder delivery options outside potential monopoly services and private providers.

At a minimum, organisational culture will have to change markedly to progress effective relationships. Other environmental changes will also be needed to promote better relationships:

- greater policy consistency

- clearer agency roles and responsibilities

- changes to provider objectives

- the adoption of a credible and sustainable funding path.

Current legislation allows the RHA to define terms and conditions for services regardless of whether the contract is acceptable to the provider (section 51). If relational contracting always worked, this provision would not be needed, but in reality agreement is not always possible. We hope its use will decline but to ensure continuity of service, we recommend retention of section 51 of the Health and Disability Act. The RHAs' requirements automatically become the contract when the provider accepts payment.
We have described how contracting might work better. But we are conscious that this is where tensions run high between expectations and capped budgets, and that there are risks associated with our advice.

Clearly, some of the old contracting pressures and dynamics will persist. Without other changes, funder and providers working alone may be limited in developing effective working relationships, and 'win-win' contracts. The risk is there will continue to be:

- poor provider cost control leading to price pressure on the funder
- pressure on the funder to maintain access to existing services
- extreme positions floated in public, leading to community disquiet and compromising public confidence
- failure by public agencies to legitimate their roles.

Strategies for managing these risks depend on changing the roles, relationships and accountabilities of agencies involved. However, it would be unrealistic to expect great improvement unless Governments is realistic about the resources needed. There must also be greater acceptance by the Government and the public of the number of services which can be delivered with those resources. Finally, it is important to be realistic about the current state of relationships between the funder and Crown-owned providers: institutional memory of poor relationships means they will not improve overnight.

We recommend to the Ministers that:

(a) Funder/provider contracts reflect
   - progressively more focus on desirable health and independence outcomes
   - effectiveness, efficiency and quality
   - the need for co-ordinated care packages
(b) While direct contracting for health and disability outcomes is desirable and should be done where possible, this is not generally feasible in the short term
(c) The funder develop the most appropriate contract forms and relationships with providers that best meet its requirements
(d) Contracts have greater regard for the relationships needed, given the nature of services and the contracting environment
(e) Decisions about what care is appropriate and when it is appropriate be delegated to those with the best information and incentives where this will mean better value while retaining accountability for good use of resources
(f) The funder have the flexibility to contract for the best services from the best providers to make the best use of resources, in line with guidelines for operationalising the Coalition Agreement (section 2 d (ii))
(g) Section 51 of the Health and Disability Services Act 1993, allowing the funder to require provision of services for a certain price regardless of acceptability to the provider, be retained, but used judiciously by the funder.
CHAPTER 4

Roles, Relationships and
Accountabilities of the Funder

The Coalition Agreement on Health indicates the Government's intention to establish a single national funding agency to replace the four RHAs. This is to:

• reduce unnecessary bureaucracy, administrative costs and replication of effort
• plan for the future health and disability needs of the country within a broader framework
• clarify the funder's role and accountability
• improve national consistency in quality and access.

Roles

Having considered other options, we consider the Health and Disability Services Act accurately summarises the Government's overall objectives for the health and disability system, namely:

• securing for the people of New Zealand the best health care or support for those in need of it, and the greatest independence for those with disabilities that is reasonably achievable given the funding provided
• facilitating access to personal health and disability support services
• achieving appropriate standards of health and disability support services.

In our view, the funder's primary goal should be:

• promoting people's personal health
• promoting care or support of those needing services
• promoting the quality of life and independence of people with disabilities
• improving, promoting and protecting public health
• meeting the Crown's notified objectives

as far as possible within available resources, by funding and facilitating access to the appropriate combination of health care and disability support services, health promotion and public health measures, to meet the population's health needs.

The funder must actively balance national consistency of quality and access, while responding to local needs in setting funding priorities. National objectives and priorities will be set by the Minister of Health. Local priorities must be determined by the funder in consultation with local communities, and drawing on the experience and information of service providers.

The funder's functions include:

• determining current and future health care and disability support needs
• setting priorities within available funding

7 The Crown's current objectives for health include the health gain priority areas: Māori health, mental health, children's health and environmental health.
• developing policy related to longer term strategic interests and priorities, programme
design, service guidelines, development and service level specification, internal
operational policy, and contributing to strategic policy advice developed by the
Ministry of Health
• developing standards for quality and efficiency
• developing, negotiating and managing contracts which include monitoring and
accountability mechanisms
• contracting for service co-ordination
• monitoring provider performance against contracts
• participating in intersectoral initiatives.

As the dominant funder of health and disability services in New Zealand, the funding
agency will have an interest in ensuring sector development to guarantee quality
provision. We see the funder's primary role as clarifying and signalling its longer term
strategic interests and priorities, indicating areas for development in the medium term,
rather than responsibility for the viability of providers per se. But the funder may
sometimes need to more actively encourage the provider organisation.

**Relationships**

The funder will have four key relationships:

• with the Minister of Health
• with providers
• with other government agencies
• with communities and the public.

**THE MINISTER OF HEALTH**

The funder's primary relationship is with the Minister of Health – the funder is the
Minister's agent and responsible to the Minister for funding services on behalf of the
public within Government policy. We see this relationship as based on shared objec-
tives, with a focus on major results and risks, co-operative informal working relation-
ships and good faith, rather than being legalistic or relying on complete specification
of all obligations.

Within this relationship, we see the Minister's role as providing policy objectives and
broad strategy for the funder, and agreeing high level performance expectations with
the funder to give effect to them. This is discussed later. The funder would be
responsible for management decisions and day-to-day operations, to meet the Minis-
ter's broad objectives.

**PROVIDERS**

The funder's relationship with providers, and moving from 'purchasing' to 'funding', is
discussed at length in the chapter on contracting.

The relationship between the owner of the Crown-owned providers and the funder
can be improved by more open exchange of information, especially on issues of:

• capital investment, which must be underpinned by long term funding intentions
• provider performance, where the funder has information on the comparative effi-
ciency and effectiveness of providers which could help the owners monitor them.
OTHER AGENCIES

The funder should develop good relationships with:

- **the Ministry of Health**: we expect the Ministry of Health to have primary responsibility for strategic advice to the Government on improving health status including, for example, developing intersectoral approaches, advising on the role and responsibilities of government agencies, and advising on the level of resources for health and disability support services. We expect the funder to make a significant contribution to this advice from its knowledge, information and experience.

- **government agencies in other sectors**: to most effectively influence health status, the Government must make a concerted effort towards co-ordinated policy across other sectors which influence health. This will need joint planning by the funder and other sector agencies, in line with the Government's strategic policy initiatives.

- **ACC**: the Government has recently confirmed that ACC should take over from RHAs direct responsibility for contracting with public providers for elective surgery related to accidents. We note that the separation of ACC purchasing potentially poses a serious risk to the integrity of the funding system. We are concerned that ACC's involvement in direct contracting with health and disability support providers will expand. Future consideration of options should take into account:
  - how to minimise the risk of cost shifting between ACC and the funder
  - the practical problems of providers facing different access criteria and/or quality requirements
  - rationalisation of information requirements on providers
  - public expectations of equity of access.

We note that ACC and the funder will have to work closely together and resolve any differences to ensure co-ordination and reduce costs by sharing resources where possible. Given that the funder needs to consider providers' long term clinical and financial viability, especially that of smaller hospitals, ACC should also be expected to take this into account in its contracting. The policy of co-ordinating these approaches, including Commerce Act issues, warrants Ministerial attention.

COMMUNITIES AND THE PUBLIC

The funder should consult and consider communities' values and preferences when making significant decisions on services and evaluating costs and benefits of new programmes. It will need to develop positive relationships with communities. We discuss issues of community participation later in this report.

**Accountabilities**

A lot rides on the performance of the funder - a monopoly with large powers and responsibilities - so monitoring and performance accountability are critical. Sound accountability is central to funder effectiveness and sector performance. The Coalition Agreement on Health signals the importance of accountability. The Ministry of Health's 1996 RHA accountability review identified two broad themes:

- the need to shift from a legalistic relationship tending towards complete specification of all obligations, to a more relational contract

- the need to reinforce statutory responsibilities through role clarification, and through greater reliance on focused performance expectations.
The accountability review provides a sounder framework for arrangements between funder and Minister than existed with RHAs. In addition, moving from four regional purchasers to one national funder is an opportunity for a more direct relationship between Minister and funder. This will help remove ambiguity and conflict about respective roles and responsibilities of RHAs and Ministry, and permit more accountability.

The funder will be accountable to the Minister of Health for its performance in meeting the Minister’s key expectations and objectives. These include the Minister’s expectations both as agency owner (for example, sound management practices, prudent risk management, living within budget etc) and of the funder as the Minister’s agent in funding services (for example, getting the most appropriate services with available resources, meeting Crown objectives and priorities, the quality of the funder’s relationships with other stakeholders, processes etc). These expectations may include outcomes where they are easy to assess and achievable by the funder.

The Coalition Agreement on Health signals the importance of sector accountability. Given the level of resources the funder is responsible for, and the importance of its task to the well-being of all New Zealanders, clear accountability is critical to its effectiveness, and the overall performance of the sector.

As well as being responsible to the Minister of Health for its performance in meeting key Ministerial expectations and objectives, the funder will also be accountable to Parliament for performance against its Statement of Intent.

The success of this framework will depend on the development of a clear set of high level performance expectations, and indicators of performance. These performance expectations should include:

- funding the best services with available resources to meet people’s needs, and Crown objectives and priorities. This may include, for example:
  - timely and transparent decision-making processes
  - effective consultation processes and responsiveness to community needs
  - the level of involvement of providers and health professionals in developing service strategies
  - the quality of relationships with stakeholders (such as providers)

- managing the organisation. This may include, for example:
  - sound management practices
  - prudent risk management
  - living within budget
  - minimising administration costs to a cost effective organisation.

A key policy question facing the Government is whether to adopt an arms-length organisational relationship between Crown and funder (for example, by establishing the funder as a Crown-owned Entity), or have a much closer relationship between Crown and funder (for example, by establishing the funder as a government department).
We recommend the funder be established as a Crown-owned Entity rather than government department. Key reasons for this are:

- Crown-owned Entity form offers more transparency and independence than is likely with a department
- board structure can include a greater range of management skills and perspectives than would normally be available in a department
- incentives and performance accountability are likely to be no greater in a department than a Crown-owned Entity.

The funder should help the Crown meet its Treaty of Waitangi obligations, and the Government should clarify requirements. We recommend Ministers consider the following options:

- making a specific provision in the legislation
- specifying the requirement in the Crown statement of objectives
- including the requirement as a key funder performance expectation
- using powers of direction.

As well as the formal accountability framework, the quality and calibre of board and senior management will be vital to the funder's performance. Much of the change this report identifies is to do with health and disability system culture. The attitudes, values and behaviour of board and senior management will impact critically on the system's dynamics. So we recommend that in appointing funder board members Ministers consider directors':

- understanding of health and disability sector funding issues
- strategic leadership, including the ability to lead culture and value change
- negotiation skills and relationship management
- experience in running large organisations
- commercial and financial skills commensurate with the resource level.

**Organisational issues**

We believe that, in general, decisions about funder organisation should be left to the funder. But we raise two issues here:

- the extent of regional and local presence
- the future of RHA subsidiary agencies.

**REGIONAL AND LOCAL PRESENCE**

A central agency will find it difficult to get enough information on local health needs (as health gain strategies vary according to ethnicity, gender, age of population, geographical access and so on) and manage local relationships with consumers and providers. Regional or local structures, and how far responsibility is devolved, will have to be determined by the funder when considering how best to meet its responsibilities.
The funder will have to consider the trade-off between the potential benefits of:

- a stronger local presence
- better information about the needs, priorities and circumstances of local communities
- better communication with local providers

on the one hand, against the potential costs of:

- inadequate risk pooling and inability to plan effectively
- administrative inefficiency
- unavailability of skilled staff
- transitional and ongoing costs of changing structures
- institutional memory and resistance to change.

Devolution of funding responsibility must take into account transaction and administrative costs. Increasing the levels of administration is only warranted where it results in better use of available funds - improved health outcomes and cost effective service delivery.

Over time, the further development of integrated care may see responsibility for local services contracted to providers or groups of providers - the role of the local office may be progressively undertaken by integrated care providers where this means better use of funds for better services.

**RHA SUBSIDIARY AGENCIES**

Subsidiary agencies, jointly owned by the four RHAs, were established in areas where joint collaborative effort offered advantages over individual RHA activity. The Government will need to consider this issue when it establishes the funder.

**Risks associated with the funder**

Sector improvement depends more on the funder's behaviour than any other single factor. Significant risks associated with some of the proposed changes are:

- the funder may not reduce bureaucracy by rationalising functions across the four regions, and between itself and the Ministry
- the funder, like any large monopolistic organisation, runs the risk of:
  - inertia and bureaucratic control
  - loss of responsiveness to local circumstances
  - dissipation of commitment and ability to minimise bureaucracy
  - developing institutional arrogance.

As we have noted, managing these risks depends on establishing a sound accountability framework. The accountability review argues for few key performance expectations reflecting Government priorities. However it is questionable whether the Crown will, in practice, be able to hold the funder to account, given that:

- the funder will have diverse functions
- it will have better information than its monitors
- performance expectations may be difficult to state or monitor
• comparing its performance with similar agencies will be impossible.

Given the importance of the funder's work to the well-being of New Zealanders and the scale of funds involved, we also recommend that the legislation reserve to the Minister the power to appoint a commissioner in the event of the funder's failure to perform.

There may be a tendency for Ministers to be drawn into the detail of the funder's work, and seek to revisit the funder's management decisions. Ministerial directives to the funder would have to be transparent to avoid undermining the funder's role and accountability.

**Recommendations**

We recommend to the Ministers that:

(a) The funder be established as a Crown-owned Entity

(b) The funder's functions include:
   - determining current and future health and disability support needs
   - setting priorities within available funding
   - developing policy for longer term strategic interests and priorities, programme design, service guidelines, service level specification and internal operational policy
   - contributing to the Ministry of Health's strategic policy advice
   - developing quality and efficiency standards
   - developing, negotiating and managing contracts which include appropriate monitoring and accountability mechanisms
   - contracting for co-ordination of services
   - monitoring provider performance against contract
   - participating in intersectoral initiatives

(c) The funder's role in sector development is to signal its longer term strategic interests and priorities to the health and disability sector and, as appropriate, take an active role in developing the sector to ensure quality provision

(d) A closer relationship between the funder and Crown's ownership interest, based on a more open exchange of information, particularly with respect to capital investment and performance monitoring of Crown-owned providers

(e) The funder consult health professionals/providers and the public and consider community values and preferences when making significant decisions on services and evaluating costs and benefits of new programmes

(f) The Ministry's 1996 RHA accountability review lays the basis for funder accountability, and key performance expectations should include measures for performance in funding the most appropriate mix of services within the resources available to meet people's needs

(g) Ministers appoint a board of directors who demonstrate:
   - understanding and appreciation of health and disability sector issues
   - strategic leadership skills
   - experience in running large organisations
   - commercial and financial skills commensurate with resource level

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(h) The funder determine how to organise itself to best meet its responsibilities

(i) The funder be charged with assisting the Crown to meet its Treaty of Waitangi obligations and the Government should clarify requirements on the funder

(j) Ensure there are no barriers, including Commerce Act provisions, to prevent the funder and ACC co-ordinating their approaches

(k) Power to appoint a commissioner to take over the funder's affairs in the event of failure to perform, be included in legislation.
CHAPTER 5

Roles, Relationships and Accountabilities of Providers

Introduction

This chapter first addresses the roles, responsibilities and accountabilities of all providers receiving public funds, then addresses public hospitals and their related services.

Because New Zealand's Crown-owned providers - that is public hospitals and their related services - account for around 50% of the annual $5.5 billion health and disability budget, it is easy to focus solely on public providers. However, it is important to acknowledge the part general practitioners, private providers, Māori providers, rest home operators and non-government organisations play in publicly-funded services.

Role of all providers

The role of all publicly funded providers is to:

• provide health and disability support services to individuals and populations, and contribute to health and independence outcomes specified in the contract with the funder
• be responsible for the quality and effectiveness of services they provide as a contribution to health gain
• contribute to the work of the funder as it makes allocative decisions
• work with the funder and other providers to ensure co-ordination and continuity of care
• observe ethical obligations in providing and managing care
• be increasingly involved with the funder, other providers and communities in planning and providing care packages and other types of service arrangements.

Relationships for all providers

The critical relationships for all publicly-funded providers are:

• with service users and communities through feedback mechanisms to ensure their services respond to consumer needs
• with the funder and other providers in working together to provide seamless care and disability support for individuals, whanau and families.

Accountabilities for all providers

Public funding raises important questions of accountability for use of those funds.

All providers must be accountable in the first instance to:

• their owners for their performance
• the funder for fulfilling contract service obligations
• service users for the quality of service they receive.

Beyond that, provider financial accountability to the funder, required under the Coalition Agreement (Principle VI), should be achieved through:
• public availability of all contracts (unless there are compelling reasons against it)
• the funder's power to audit provider performance in terms of services provided from public funds
• public disclosure about service performance by providers against contract (without compromising privacy).

We note that currently contracts can be made available under the Official Information Act (OIA), and all requests for disclosure are treated as OIA requests. In recommending public disclosure there is a presumption that all contracts be released. In our view, disclosure of contract specifications and aggregate prices has two effects:

• while there is a risk it may lead to price pressures on the funder, it also means the funder must explain how it arrived at its prices. This transparency is important to funder accountability, our concern with which we have noted before.

• it exposes provider performance to the same scrutiny: if one provider's performance is less efficient than another's (either in terms of price or quality), it is likely to come under community and ownership pressure to improve efficiency of delivery. It will also help preliminary benchmarking of providers' performance.

It is the funder's responsibility to ensure all contracts contain adequate accountability and monitoring. This is especially important when contracting with organisations which hold budgets and make allocative decisions. Providers also have an obligation to use public funds ethically.

**Role of Crown-owned providers**

Crown ownership of hospitals and associated services helps ensure access to services against the risk of contract failure. However, it is unnecessary to own all providers to guarantee access, given public funding of health and disability support services.

The Coalition Agreement requires removal of the profit focus for Crown-owned providers. We recommend it be replaced with the following objective:

"to provide health and disability support services which contribute to health status through improvements in quality, levels or costs of service as agreed with the funder, and to do so in a manner which ensures effective and efficient use of resources".

The removal of the profit focus and the competitive environment, while fundamental, does not change the need for 'businesslike' management, as signalled in the Coalition Agreement. This includes:

• strategic leadership, or effective management of resources today while shaping the organisation to meet the challenges of tomorrow
• an ethic of maximising value for the taxpayer. In the new environment, this means improving productivity and reducing unit costs
• sound management of and full accountability for use of public funds
• a culture of service to the user, focusing on meeting user needs and adding value at every step in the care continuum.
These requirements can only be achieved by:

- relational contracts which offer incentives for improvement
- organisational leadership at all levels (including owners)
- governance arrangements providing credible sanctions and incentives.

The Steering Group believes Crown-owned providers should aim to improve the quality as well as the efficiency of the care they provide. They should do this through:

- focusing on service user needs and how they can be best served from available resources. Services should be provided for the benefit of those who use them, not those who run them
- providing care based on best available evidence, and constantly innovating to provide better services
- provide for safety in care. A key public concern is quality of care, including its appropriateness in different cultural settings (particularly by and for Māori)
- striving to be more efficient.

The Steering Group emphasises that managers and clinicians have equal responsibility for the quality and efficiency of the care they provide. Quality and efficiency of care should be central values for Crown-owned providers.

**RANGE OF SERVICES**

The Coalition Agreement states a commitment to providing a range of services by new public providers. The listed services are: community and rural health; mental health; Māori health; dental health; public health (including health protection and promotion); intellectual, age-related, physical/sensory disability support services; maternity (including pregnancy and childbirth services); well-child services; accident and emergency services; secondary/tertiary medical and surgical services; and diagnostic services.

Some CHEs do not provide the full list of services, and the Steering Group believes it would be a retrograde step to require them to develop the capacity, especially where the service is satisfactorily delivered by other providers (i.e., where there are no 'gaps' in care). In some cases, for example, particularly in disability services and Māori health, there may be organisations which provide them more cost effectively or appropriately than Crown-owned providers. The list does not indicate a desire to expand services regardless of need. Effectiveness and efficiency of care is more important than who is providing it.

**CO-ORDINATION OF CARE**

In most cases, Crown-owned providers are unlikely to have any natural advantage in being the link between services. Co-ordination of care within a particular service is, however, an area where they may have an important role. This might be the case for a service needing specialised skills and where the public provider was already heavily involved - for example, in the provision of renal dialysis services. In other cases, another provider or group may be better placed to co-ordinate care, and the Crown-owned provider will work with them to ensure seamless care. In still other cases, Crown-owned providers may not be involved at all. This diversity underlines the need to approach co-ordination on a case-by-case basis.
The culture of Crown-owned providers must change if relationships are to improve. We are concerned that some health professionals feel alienated by business management jargon and CHEs' commercial objectives. We expect this will be resolved by:

- removing the profit focus
- requiring the funder to involve providers in service development
- better alignment of management and health professionals on productivity and quality objectives.

However, Crown-owned providers should also seek to increase health professionals' participation in managing the organisation. This means more involvement in contracting, planning and day-to-day management of services. At the same time, health professionals must recognise the importance of management. The need for management skills will grow rather than diminish, and we support professional health management development.

In respect of Crown-owned providers' external relationships, a change in objective, and emphasis on relational contracting should lessen tension in the relationship with the funder. Because of the capped budget, however, some tension is inevitable. The challenge is to make it constructive by involvement in and greater dialogue on service development, future service strategies and improved information flows.

Crown-owned providers should also co-operate more with other providers, especially Māori providers, in providing seamless care. There is no call for secrecy among Crown-owned providers under the new arrangements because they will not be in competition. 'Commercial sensitivity' is unlikely to be an acceptable reason for not co-operating with each other in pursuit of more effective and efficient delivery of care.

Finally, Crown-owned providers should seek to reduce professional, administrative and budgetary barriers to integration of primary and secondary care. This should improve co-ordination for service users, and the effectiveness and efficiency of services.

In the first instance, the Crown-owned provider is, like any other provider, accountable to the funder for performance against contract. Second, it is accountable to Parliament through the shareholding Ministers (the Ministers of Health and Finance) for performance against its Statement of Intent. This should include financial and non-financial performance indicators.

In recommending this accountability, we are explicitly endorsing the not-for-profit company model. We do so because:

- we have seen little evidence that other options, such as statutory corporations, government departments and other not-for-profit forms, would be demonstrably better
- the company form is well-established and understood with clear governance and accountability, and can accommodate the changes we propose
- a change in form could lose experienced people, and we want to minimise that risk.
COST OF CAPITAL

A fundamental requirement is that the not-for-profit companies cover all costs including the cost of capital so they are financially viable over time. This cost should be:

- seen as a tool for sound management and investment decisions within Crown-owned providers, and sound pricing decisions by the funder
- funded so services are not reduced as a result of the new regime
- set so the not-for-profit status is clearly honoured.

Officials should develop appropriate mechanisms for observing these principles.

CO-ORDINATION OF PROVIDERS

The Government should also address the need for greater co-ordination of public providers, especially in:

- significant capital investment
- monitoring Crown-owned provider performance on a consistent and comparable basis
- reconfiguration of services and organisations across national and international boundaries
- industrial relations strategies
- making the best use of available management talent.

Among the options the Government should consider are:

- dedicated CCMAU health monitoring with more of a co-ordinating role, reporting to the Minister of Health, or
- a parent board and secretariat accountable to Ministers for performance of the Crown-owned provider sector.

DEFICIT SUPPORT

Finally, the existence of deficit support for CHEs has:

- weakened provider accountability
- confused responsibility for purchase roles
- made sound pricing difficult, leading to poor purchase decisions
- hampered the development of constructive contractual relationships.

It may be that deficit support is partly a consequence of funding initially set on the basis of optimistic expectations about CHE efficiency. Deficits are currently made up of:

- over-production of services, some of which the RHA wants, but others representing poor volume management by Crown-owned providers
- poor cost control by Crown-owned providers
- under-pricing by the RHA.

To the degree that deficit support prevented CHEs from exiting genuinely under-funded services, it has been a safety valve for the taxpayer.
Crown-owned providers should be established on a sound, sustainable financial footing, and deficit support removed. This will require repricing services. However, there are many risks associated with this, and on its own it will not prevent re-emergence of deficits. For that reason, a ‘deficit switch’ should not be contemplated in isolation from:

- realism on the part of owner and funder about the gains and financial performance organisations can sustain
- moving to more sustainable and credible funding
- changing the capital structure of CHEs
- improved accountability for performance involving:
  - responsibility for re-emergence of future deficits arising from lack of cost control, which should rest with the owner, not the funder
  - responsibility for better volume management resting on the funder and provider working together to identify the nature of demand
  - mechanisms to discourage the re-emergence of deficits from funder and/or provider opportunism
- incentives for providers to improve quality and productivity rather than focus only on the bottom line.

There are a number of general risks as well as risks which arise specifically from these proposals:

- Crown-owned providers might not develop effective arrangements with other providers and communities, and recent gains will be lost
- lack of sector acceptance or understanding of new agency roles and responsibilities, leading to cost pressures driving sector funding
- if sector refunding is delayed, the new environment will lack credibility
- changes to accountability dynamics arising from any decisions on new monitoring arrangements
- new objectives might be seen as more vague than current ones, making accountability more difficult. Uncontrolled volumes, and concerns about ‘quality’ might drive costs if health and budget needs are not balanced.

One of the management strategies advanced here is the deficit switch, which can move the funder/provider relationship on to a new footing. However, there are associated risks:

- realising efficiency gains through higher quality and greater productivity (if this is agreed with the funder) rather than cost reduction. This will require more funds to be transferred in future years than currently budgeted for and so will have some fiscal impact in future years
- pressures for cost control might ease as a result of the deficit switch, or deficits might re-emerge after the switch if it is perceived as a ‘bail out’
- a poorly conceived or implemented deficit switch might further alienate health professionals, as well as fail in its intentions of:
- restoring organisations to a sound financial footing
- developing appropriate pricing
- providing incentives for cost control and volume management.

Even without the switch there are risks of cost growth. Cost control incentives and sanctions must be strengthened, and future funding must be credible, but responsibility for any lack of cost control lies with the owner not the funder. Greater disclosure of provider performance information is important in risk management.

**Recommendations**

We recommend to the Ministers that:

(a) The role of all providers is to:
   - provide health and disability support services to individuals and populations, and contribute to health and independence outcomes specified in the contract with the funder
   - be responsible for the quality and effectiveness of services they provide, as a contribution to health gain
   - contribute to the work of the funder as it makes allocative decisions
   - work with the funder and other providers to ensure co-ordination and continuity of care
   - observe ethical obligations in providing and managing care

(b) An information disclosure regime is developed. This would cover statements of service expectation and performance, and revenue from public funds

(c) The objective of Crown-owned providers is to provide health and disability support services which contribute to health status by improving quality, levels or costs of service as agreed with the funder, and to do so in a manner which ensures effective and efficient use of resources
   - Crown-owned providers be reconstituted as not-for-profit companies
   - while not-for-profit, Crown-owned providers to be businesslike. This includes:
     - managing the organisation so it is efficient and effective over time
     - maximising value by continuously improving productivity
     - practising sound financial management and accountability
     - focusing on service to the user

(d) A satisfactory mechanism, consistent with the not-for-profit form, be developed to ensure capital costs are reflected in sector management, investment and funding decisions. Funding should be adjusted so that introducing this will not impact on service levels

(e) Individual Crown-owned providers not have to provide the full range of services outlined in the Coalition Agreement on Health

(f) No significant change to governance or reporting arrangements for Crown-owned providers. They would be:
   - registered as companies owned by the Minister of Health and the Minister of Finance
   - run by appointed boards
   - monitored by CCMAU or a parent board
(g) The reliance of Crown-owned providers on deficit support be removed by repricing services, but this not be considered in isolation from:

- sustainable and credible funding
- a review of Crown-owned providers' capital structure
- improved incentives and performance accountability, including disclosure of performance
- mechanisms and incentives to improve management of service levels and costs within hospitals
- being clear that responsibility for future deficits arising from lack of cost control rests with the owners, not the funder

(h) There be greater co-ordination of all Crown-owned providers, and more work should be done on how this is best achieved.
CHAPTER 6
Roles, Relationships and Accountabilities of Central Agencies

Introduction
This chapter develops recommendations for the roles and functions of central agencies - the Ministry of Health, the National Health Committee, The Treasury/Crown Company Monitoring Advisory Unit, Te Puni Kōkiri, and the proposed Māori Health Promotion Unit, the Mental Health Commission, the New Zealand Health Information Service and the Residual Health Management Unit - and how these agencies coordinate their activities, co-operate and resolve conflicts. They have important statutory responsibilities, occupy leadership positions in the sector, and are important contributors to the way funder and providers manage their own relationships.

Roles
MINISTRY OF HEALTH
The Ministry should primarily keep an overview of the performance of the sector as a whole. However, it should also consider non-health factors contributing to health status (for example, housing, education, employment etc). It should exercise this leadership through:

• strategic policy advice about outcomes and strategies for advancing the health status of New Zealanders. This means advising the Minister of Health on health sector funding, and appropriate funder objectives and performance measures. Operational and services policy, such as service guidelines and access requirements, should be the funder’s primary responsibility

• establishing and promoting links between health and other sectors which influence health status and independence

• monitoring funder performance against the objectives agreed with governments. It should also monitor ownership interest in the funder (ie how effectively and efficiently it is managing itself, as opposed to carrying out its funding functions

• provision of informed, independent advice to Ministers about sector performance in particular service policy areas

• developing a framework to consider regulatory health interventions

• regulation, which needs further development on:
  - mental health and the role of the Director of Mental Health
  - safety and licensing
  - public health

• assessing workforce and infrastructure needs on the advice of the sector, and initiating ways to meet those needs, especially when intersectoral co-ordination is needed.
NATIONAL HEALTH COMMITTEE (NHC)

We believe the NHC should continue to advise the Minister of Health. It should report on evidence of clinical and cost effectiveness of particular interventions in improving health and independence outcomes. It should contribute to the debate on fair rationing by ensuring dialogue between clinical and policy perspectives.

However, it cannot carry out that function independent of sector budget constraints. It is critical that NHC work is well grounded and takes into account the funder’s resource constraints, otherwise its usefulness will be limited. The NHC must consult the funder about its advice and the latter’s ability to implement that advice within budget. The NHC should try to reach agreement with the funder in developing its recommendations. Where agreement cannot be reached or the implications of the NHC’s work are that it will go beyond the funder’s resources, the NHC should be explicit about additional costs. While we expect this dialogue to be ongoing and the parties to reach agreement, the NHC should obviously be able to disagree and advise the Minister of Health accordingly.

Because its emphasis is on health and independence outcomes as opposed to budget constraints, the NHC should remain independent of the funder. This means it should continue to report to the Minister of Health and be serviced by the Ministry.

CROWN COMPANY MONITORING ADVISORY UNIT (CCMAU)

Decisions on the role of CCMAU are closely related to proposed strengthening of monitoring and co-ordination, either through CCMAU, a ‘parent board’ or other options, and how this could operate (refer Chapter 5). While those options are being considered, CCMAU should continue to monitor the financial and non-clinical performance of Crown-owned providers against their Statements of Intent.

The Coalition Agreement on Health proposes that providers report to the Minister of Health via the Ministry of Health. We endorse the requirement that they report to the Minister of Health as one of the share-holding Ministers. But, we believe Crown-owned providers ought to report directly to the Minister rather than via the Ministry of Health. CCMAU should continue to monitor the performance of the Crown-owned providers and advise shareholding Ministers, because:

- the Minister should bring together ownership and funding perspectives, rather than an agency. The Government has addressed that by charging the Minister of Health with the statutory responsibilities of the Minister for Crown Health Enterprises
- we see no gain in change - CCMAU resources and personnel would have to be transferred to the Ministry. The Treasury would still advise the Government on the fiscal implications of providers’ financial performance. The problem of co-ordinating advice to Ministers would remain, and there would be no reduction in bureaucracy
- decisions about the parent board should be made before decisions on location of the monitoring function
- while there could be advantages in bringing monitoring of the funder and Crown-owned providers into one organisation, by internalising balanced perspectives, there is the question of provider perceptions of conflicts of interest, and potential complications in the relationship between funder and provider. On balance, we consider the Ministry of Health should not monitor the ownership interests in Crown-owned providers, but it will be important to ensure monitoring activities are aligned to provide quality advice to the Minister of Health.

The UK model has purchaser and provider monitoring within the National Health Service (NHS) executive, but that is separate from the Ministry of Health. An equivalent here would be a new agency, which is contrary to the non-negotiable principle of limiting bureaucracy.
• separate dedicated ownership monitoring is important to fulfil the businesslike requirement on the provider. CCMAU has wide experience in monitoring Crown companies. Monitoring and accountability remain important regardless of the providers' not-for-profit status. The monitor's culture should reflect that of the providers, and we recommend monitoring remain with CCMAU while the parent board and other options are considered.

THE TREASURY
To date, The Treasury has been involved in monitoring and advising the Government on the financial performance and effectiveness of Crown-owned providers. It too has an overview role through:

• advice to the Treasurer and the Minister of Finance on Vote:Health
• advice on provider performance issues to the Minister of Finance as shareholding Minister
• advice on the Ministry of Health's and CCMAU's performance as part of its departmental vote analysis.

We understand The Treasury has recently consolidated the first two roles, and is taking more of an overview of the Vote and the portfolio. We recommend no change to these roles.

MENTAL HEALTH COMMISSION
The Mental Health Commission was established to monitor and advise the Minister of Health on the performance of health agencies (primarily the Ministry of Health and RHAs) on all aspects of implementing the mental health strategy, but in particular, the ability of agencies to account for mental health expenditure. If the Mental Health Commission Bill currently before Parliament is passed, the Mental Health Commission will be established as a Crown-owned Entity with a five-year life.

However, the Coalition Agreement endorsed full implementation of the Mason Report, which recommended a funding role for the Commission. In our opinion, that option is not consistent with the rationale for a single national funder, and would diminish its accountability. We recommend the funder and the Commission develop a close working relationship which recognises their respective roles.

TE PUNI KÖKIRI (TPK)
Te Puni Kōkiri has three roles which impact on how the sector functions:

• monitoring the Ministry of Health on its delivery of the Māori health strategic vision, including an audit process
• policy advice on Māori development (particularly as it relates to Ka Awhata 1991 (refer Chapter 8) which has particular relevance given the inter-relationship between Māori health, Māori development and the development of Māori providers
• advice on the establishment of a Māori Health Promotion Unit. The function of the unit has not yet been determined, but care should be taken to ensure roles and accountabilities are not duplicated.
NEW ZEALAND HEALTH INFORMATION SERVICE (NZHIS)

Information is both a key gain of restructuring to date and a key ingredient of sector improvement in the future. NZHIS can lead development of the infrastructure encouraging use of better information for decision-making. Currently it is part of the Ministry of Health, but we note the Ministry is exploring the advantages of a stand-alone agency available for use by all sector agencies and not aligned with any one in particular. We note the importance of developing an ethical information and privacy strategy as part of that work.

RESIDUAL HEALTH MANAGEMENT UNIT (RHMU)

This small agency currently acts as the Crown's banker to CHEs and manages residual liabilities from former area health boards. Its roles and responsibilities should be reviewed in light of any review of the capital structure of Crown-owned providers.

Relationships

To provide leadership, central agencies will have to balance good understanding of the issues from funder/provider perspectives, against intrusion which might compromise accountability or effectiveness. This means that:

- where the Ministry of Health has primary responsibility for advice (for example, strategic and funding), it will need to consult and work with the funder about the appropriateness and sustainability of its policy proposals. Similarly, where the funder has primary responsibility (for example, service guidelines, access requirements etc), it will need to work with the Ministry to ensure consistency with the Government's broader strategies

- the Ministry of Health should lead and promote intersectoral co-ordination as a way of addressing drivers of health status which lie outside the responsibility of funder and providers of health and disability services

- the central body monitoring the performance of Crown-owned providers, will, regardless of its form or location, need to ensure an appropriate level of local provider board autonomy, and that it does not get in the way of the funder/local provider relationship

- the roles and responsibilities of the funder and Te Puni Kōkiri must be clarified. It is the funder's role to foster innovation and fund appropriate services for Māori. Furthermore, the funder is responsible for fostering Māori provider development and service user input. Te Puni Kōkiri and the funder must establish a relationship which ensures the funder's interventions are consistent with future work on the Government's policy framework for Māori development

- it is important the roles of central agencies are clear and co-ordinated to avoid sending mixed signals to the sector.

Accountabilities

- Ministry of Health - accountable to the Minister of Health

- National Health Committee - accountable to the Minister of Health, but in close consultation with the funder

- CCMAU (or any parent board) - accountable to the Minister of Health and the Minister of Finance as shareholding Ministers
• The Treasury - accountable to the Treasurer and the Minister of Finance for Vote:Health funding issues, and the Minister of Finance for monitoring ownership interest

• Mental Health Commission - accountable to the Minister of Health

• Te Puni Kōkiri - accountable to the Minister of Māori Affairs

• Residual Health Management Unit - responsible for administrative purposes to the Ministry of Health but advises shareholding Ministers. This anomaly could be tidied up, but it has low priority

• all public agencies are subject to the scrutiny of the Ombudsman in respect of official information, the office of the Auditor-General in respect of the Public Finance Act, and the Health and Disability Commissioner in respect of powers under the Health and Disability Commissioner Act.

*Risks associated with central agencies*

Improvement in central agency co-ordination depends on improving the relationships and performance of the agencies they monitor. However, risks that need to be recognised are:

• poor alignment which could lead to:
  - confusion in roles between agencies
  - duplication of effort
  - higher levels of bureaucracy than are warranted
  - mixed signals to funder and providers which in turn affect relationships

• distance of central agencies from providers and service users that can erode the quality of advice offered to Ministers

• potential confusion of roles between funder and Te Puni Kōkiri (including the role of the Māori Health Promotion Unit) if their roles are not absolutely clear in respect to Māori provider development responsibilities

• careful management to meet the Coalition Agreement requirement to reduce net bureaucracy. Increased administration is almost inevitable in a transition, and a number of the recommendations in this report may increase rather than reduce administrative costs, for example:
  - adopting a more relational approach to contracting
  - resources needed for co-ordination and monitoring by funder and central agencies
  - ‘administrative creep’ between the Ministry of Health and the funder as each agent acquires resources for second opinion capacity, resulting in disputes about roles
  - increased local responsiveness.

However, we expect these to be eventually offset by:

• opportunities to rationalise service policy functions between the Ministry of Health and the funder, where the Ministry currently works on programme design, service level specification and service guidelines

• rationalising functions across regions wherever possible. Some resources should be freed up where each RHA has developed its own approach and duplicated effort.
**Recommendations**

We recommend to the Ministers that:

(a) The role of the Ministry of Health is to:
- have an overview of the health and disability sector and non-health factors contributing to health status
- give strategic policy advice about outcomes and strategies for advancing the health and independence status of New Zealanders
- establish and promote intersectoral links
- monitor the performance of the funder against its objectives and management performance
- provide independent policy advice on specific significant service policy areas
- assess workforce and infrastructure needs and prompt initiatives
- implement the regulatory framework

(b) There is no change to the role of the National Health Committee, but its advice should take account of the funder's ability to implement it within its budget

(c) There is no change to the role of the following agencies in respect of their health activities:
- The Treasury
- Te Puni Kōkiri

(d) The role of the Crown Company Monitoring Advisory Unit be decided in light of decisions about a parent board or other options for Crown-owned providers. Until those decisions are taken, CCMAU continue to monitor the performance of Crown-owned providers

(e) The provision in the Mental Health Commission Bill that the Mental Health Commission be a Crown-owned Entity with a life of five years is supported by the Steering Group. We do not support a funding role for the Commission, but recommend that the Commission and the funder develop a close working relationship

(f) Work to continue to determine whether the New Zealand Health Information Service should be a stand-alone agency, and a strategy for dealing with ethics and privacy issues be developed

(g) The role of the Residual Health Management Unit be reviewed by officials in the light of any review of the capital structure of Crown-owned providers.
CHAPTER 7
Disability Support Services

Introduction

RHAs have been responsible for purchasing most disability support services (DSS). They were expected to:

- make efficiency gains
- develop more flexible purchasing options
- cap the budget
- be more responsive to the needs of service users.

A framework for DSS was developed, separating out three components in the process of service delivery. These were: needs assessment, service co-ordination and service provision. The separation was seen as avoiding 'provider capture' and ensuring people had fair access to the services they needed. RHAs were expected to purchase these services from separate agencies.

Four major problems have been identified with current arrangements. These are:

- a tendency to treat disability support clients as if they were one group. There are significant differences between and within client groups. For example, people with a physical or sensory disability can make their own decisions and co-ordinate their own support requirements, whereas people with an intellectual disability generally need someone to act on their behalf. There are different expectations for DSS services from particular populations, such as Māori

- a move to third-party purchasing has had some unintended results. It has involved two moves: firstly, from providing cash assistance to an individual, to providing in-kind assistance (or services). Secondly, the purchasing model created a purchasing agent, rather than letting individuals arrange their own services. Concerns have been expressed about these moves, for example:
  - some service users and their families are well able to make choices about home health, childcare etc (but may lack adequate income)
  - formal contracting processes and the nature of relationships between RHAs and providers have increased providers’ administrative costs. This has proved particularly difficult for small providers, although there have been acknowledged benefits from the purchasing process

- specifications of disability/personal health interfaces have not been analysed. For example, people with chronic mental illness and some frail elderly (for example, with progressive debilitating conditions) have frequent contact with personal services because of their disability. By contrast, most people with an intellectual or sensory disability have levels of contact with health services similar to individuals without a disability, and for reasons unrelated to their intellectual disability. Furthermore, people with primarily a medical background may be assessing and coordinating the needs of individuals with a disability when the needs of those individuals are not medical
- administration costs, particularly those associated with needs assessment and service co-ordination, have increased. These costs arise from three factors:
  - service users feel they have to provide the same information to two agencies undertaking needs assessment and service co-ordination, and also to providers delivering services
  - needs assessment and service co-ordination is a compulsory step to gaining assistance - this was felt unnecessary by some service users with stable, well-identified needs who are able to assess and co-ordinate responses to their own needs
  - many service users now feel they know too little about what services they can expect to receive.

**Principles for funding disability support services**

We believe some modifications are required to ensure services better meet the needs of service users and realise efficiency gains. The critical elements are:

- increasing flexibility
- empowerment of service users
- better links between services.

We believe these changes should include:

- recognition that some service users can organise services to meet their own support requirements and are aware of their own needs. There should be greater flexibility for the role of the agent (the individual or organisation making a decision on behalf of a person with disabilities)
- where there are clear benefits from integrating needs assessment and co-ordination processes, the existing requirement to separate them should be lifted
- strengthening the needs assessment process so the individual needs assessor is competent to align assessment decisions with budgetary considerations
- allowing flexibility so service users may access services if their needs are stable and/or well-known, without having to go through a time-consuming and costly needs assessment and service co-ordination process
- allowing flexible use of cash assistance as opposed to purchasing services on behalf of service users. This needs careful evaluation of the circumstances under which cash assistance should be given to ensure it stays within budget, and evaluation of its success
- allowing flexibility for the funder to use its discretion developing strategies aimed at helping service users
- better definition and clarity for service users about conditions of access to services (or cash assistance)
- improving links with government agencies offering suitable services for people with disabilities, for example, employment placement, day services, vocational training and education services
- further development of a culturally appropriate framework for DSS for Māori, such as that proposed in *He Anga Whakamana* (1995). The framework should be based on three cornerstones:
  - te ha o te tangata - respect for clients
- te herenga tangata - a community focused approach
- whakapakari Māori - workforce profiles.

Each cornerstone should be considered on two levels:
- the disability itself, which does not necessarily require any different distinction between Māori and non-Māori people
- consideration of the cultural factors relevant for Māori people with disabilities, and provision of culturally appropriate services where possible

• further development of culturally appropriate services for all New Zealanders.

Finally, DSS should move towards greater integration of services. However, it is important to avoid inappropriate medicalisation. At some stage, it may be appropriate to reassess the ring-fencing of disability support funding from personal health funding, but not until there is greater confidence about accountability arrangements.

**Risks associated with DSS**

Risks to be considered for future policy development are:
- any move to providing service users with cash assistance will have to be carefully managed so as not to create unrealistic expectations (and pressure) about the capacity of the funder's budget to purchase disability support care
- non-government organisations are concerned at the prospect of being displaced by Crown-owned providers, regardless of considerations of cost effectiveness and service quality
- over time, disability sector goals of support for independence may be subsumed by a medical model.

**Recommendations**

We recommend to the Ministers that:

(a) There be greater flexibility for individuals who have stable, well-identified needs to have more opportunity to organise their own support services

(b) The existing requirement to separate needs assessment and co-ordination processes be lifted where there are clear benefits from integrating them

(c) The existing needs assessment process be strengthened for greater consistency and quality

(d) The funder have flexibility to develop different approaches to implementing its contracting strategies, including being able to supply cash rather than in-kind assistance

(e) Service users be provided with better information about conditions of access to services or cash assistance

(f) Links with government agencies offering services for people with disabilities to be improved

(g) A culturally appropriate framework for DSS be further developed for all New Zealanders, particularly Māori.
CHAPTER 8
Whakamaua kia tīna – Building on Gains in Māori Health and Independence

Introduction
There have been recent significant gains in Māori health development. But despite these, Māori continue to lag behind non-Māori in almost every indicator of health status. Māori issues are identified throughout this report. This chapter deals with fundamental matters in more detail. Three key issues are:

• Māori health remains a health sector priority for improvement, as indicated by the current Crown objective and strategic framework for the improvement of Māori health

• the need to consolidate gains in Māori health development and accelerate Māori participation in the sector

• the need to continue to acknowledge the special relationship between Māori and the Crown under the Treaty of Waitangi.

Ka Awatea - a policy framework for Māori development
The Government’s approach to the Treaty of Waitangi is confirmed in the Māori policy provisions of the Coalition Agreement. These provisions also provide for the implementation of Ka Awatea, as amended. Ka Awatea (1991) states that positive Māori development is key to addressing Māori social, cultural and economic well-being, and reducing disparities between Māori and non-Māori.

Ka Awatea proposes that the Government articulates and implements an outcome for Māori, and that the outcome be addressed by:

• the Minister of Māori Affairs co-ordinating and providing leadership to ensure collective political support

• all departments and agencies targeting disparities and reducing Māori dependence on the state, adequately resourcing quality services for Māori and clear accountability arrangements to ensure responsibilities to Māori are met.

The developmental objectives of Ka Awatea are reflected in the Māori health policy provisions of the Coalition Agreement. These include accelerated development of Māori providers and the Māori health professional workforce, increased public health resources for Māori health, a focus on health gains and outcomes, and continued improvements in the effectiveness of Crown-owned providers.

Themes for Māori health development
The Steering Group recommends the following nine themes feature in health and disability sector evolution to ensure Māori needs are addressed. These themes are consistent with current strategic frameworks for Māori health over the past three years, and with the health and Māori policy provisions of the Coalition Agreement.
RANGATIRATANGA

This is the recognition of provisions and principles of the Treaty of Waitangi and their application to health sector roles and accountability arrangements. It also recognises Māori aspirations for autonomy and self sufficiency with reduced reliance on the state and development of services managed by Māori. It will require a vastly improved capacity for Māori to participate at all levels, and in close association with others in the health and disability sector. It also recognises the importance of linking Māori health with other aspects of Māori development.

ACCESS TO QUALITY MAINSTREAM SERVICES

This is one element of a dual strategy to provide appropriate services for Māori. Given the number of Māori service users needing access to mainstream services, those services must be safe, equitable, culturally effective and appropriate. Relevant outcome measures will be critical to evaluating the strategy.

NEW AND EXISTING MĀORI PROVIDERS

The other element of this strategy is provision of services by not-for-profit Māori providers. Māori providers are critical to improving Māori health and their role will be consolidated. As well, Māori providers will continue to be encouraged. The need to extend the range of services Māori provide will be highly significant for Māori workforce development. Similarly, new Māori services will have establishment and development implications.

GAINS AND OUTCOMES

This means recognising the significant progress Māori health has made over the past four years and ensuring it is not lost in new health and disability sector arrangements. Key to this theme is keeping Māori health and independence a priority, and developing outcome measures which reflect both clinical and cultural dimensions.

AUKATI - PREVENTION/PROMOTION

Disease prevention and health promotion give the best opportunities for significant long term Māori health and independence gains. While this emphasises proactive health and independence improvement, it should not be at the expense of treatment services. However, it does require approaches which make sense to Māori communities, recognising the diversity of Māori society and contemporary realities. Primary, secondary and tertiary preventive strategies should be used and evaluated. They should include early intervention as well as active promotion of good health.

TIKANGA MĀORI AND KAUPAPA MĀORI

Along with generic development of Māori providers, there must be more support for a range of kaupapa Māori services. These include traditional healing and other services rooted in Māori health and well-being philosophies. There has been limited work on this to date, and it should be built on. It must include culturally appropriate measures of outcome and effectiveness.

INTEGRATION - INTRA-SECTORAL AND INTER-SECTORAL

Integration, co-ordination and co-operation, within the health and disability sector and with other sectors, are essential to maximising health and independence gains.
and outcomes. A comprehensive strategy with an 'outcomes approach' is needed, and integration is a prerequisite. For Māori, an integrated approach recognises that gains in health and independence stem as much from socio-economic advancement as improved health and disability services. Intrasectoral co-ordination will rely heavily on information-sharing strategies which give parties equal access.

**RESOURCING MĀORI HEALTH AND INDEPENDENCE GAINS**

This concerns allocation of resources to ensure Māori health and independence improves. Options for maintaining and increasing resources include identifying specific Māori development funding, shifting resources from the margin to the Māori health and independence gain priority area, and ensuring the new funder has strong partnership and participation strategies. Ultimately, resourcing levels need to reflect the higher level of Māori need given their lower health standards, as well as the need to resource future Māori health development.

**AWATEA - MĀORI DEVELOPMENT**

This means a holistic approach putting Māori health and independence improvement in the context of overall Māori development. It will rely on the new health and disability structures developing strategic alliances with Māori development structures, including the Māori Health Promotion Unit and Te Puni Kōkiri. It will also rely on health and disability structures and processes reflecting the Māori development approach articulated in *Ka Awatea*. Co-operation, clear roles and responsibilities, and common goals will be necessary to prevent fragmentation, duplication and conflicting leadership.

**Risks associated with Māori health and independence**

The following risks should be considered when implementing proposals to improve Māori health and independence:

- mainstream health and disability service providers may resist change focused on Māori needs
- despite change, non-Māori health may improve at a greater rate than Māori, especially if socio-economic disparities are not reduced
- the greater Māori involvement in health and disability services of the last few years may not be sustained. The risk of this will be increased if too much emphasis is put on Crown-owned providers and not enough on Māori
- Māori workforce development may not keep pace with Māori service needs.

**Recommendations**

We recommend to the Ministers that:

(a) Māori health remain a health and disability sector priority for improvement
(b) Gains made in Māori health development be consolidated and Māori participation in the health and disability sector accelerated
(c) The special relationship between Māori and the Crown under the Treaty of Waitangi continue to be acknowledged
(d) The following themes feature in the health and disability sector to ensure Māori health and disability needs are met: rangatiratanga; access to quality mainstream services; new and existing Māori providers; gains and outcomes; aukati - prevention/promotion; tikanga Māori and kaupapa Māori; integration - intrasectoral and intersectoral; resourcing Māori health gains; and awatea - Māori development.
CHAPTER 9

Participating in Health

The benefits of participation

The Steering Group believes increased participation to reflect communities' values and preferences at all levels of the sector is important because:

- it encourages individuals and families to take greater responsibility for their own health - a view supported by a recent World Health Organisation study\(^9\) - and encourages recognition of the many factors contributing to health improvements
- it improves all publicly-funded organisations' accountability for decisions, actions and quality of care. It creates a climate of institutional transparency and honesty
- it encourages communication between organisations and their communities. The resulting information helps communities and individuals judge the performance of the organisations and make informed choices about their own care
- increased information helps organisations manage public and individual expectations of services they can provide with the funds available
- participation is critical for meeting the Crown's obligations under the Treaty of Waitangi, as defined by the Courts, to consult and conduct affairs in good faith.

Principles for participation

We believe community participation must be underpinned by these five principles:

- responsibility for ensuring communities' values and preferences are reflected in their decision-making, and for consulting and communicating, rests with funder and providers in the context of their respective roles. Ultimate responsibility and accountability for decisions lies with those organisations
- communities have the right to participate in the publicly-funded health and disability sector to ensure their values and preferences are reflected in the decision-making process. This principle could be exercised by:
  - providers actively seeking feedback from service users and their families about the quality and appropriateness of care, for example, customer satisfaction surveys
  - using existing formal and informal community opportunities, for example, local bodies or community health councils to convey values and preferences
  - using standard outlets to pass on information, for example, newsletters and public meetings
- publicly-funded health and disability organisations are obliged to encourage community participation and show they have considered community values and preferences in their decisions. This principle could be strengthened by contracts between the Minister and the funder, and the funder and providers, requiring them to show how they have reflected communities' (or, in the case of providers, service users') values and preferences in their decision-making processes and how they intend to inform the community of their decisions
- publicly-funded organisations must be encouraged to disclose as much information as feasible to let communities and individuals judge performance and make choices. This principle can be exercised by:

- requiring funder and Crown-owned providers to report annually to Parliament
- encouraging the practice of providers to publish annual reports

• the Government and its agencies must recognise the value of affirmative action to ensure participation from community groups that have shown a particular interest in an agency's activities.

**Elected representation**

Our terms of reference invited us to recommend whether or not there should be elected representation on the governing bodies of publicly-owned health and disability support organisations; namely, the funder and the Crown-owned providers. This was not an easy task. While we represent a broad cross section of the health and disability services sector, we could not claim to represent the views of communities. We consider the Government will have to look beyond the Steering Group if it wants a more accurate assessment of communities' views on elected representation.

However, given the sector structure already laid down by the Government, particularly reorganisation of the four RHAs into one national funder, we believe elected representation would be unlikely to ensure the communities' values and preferences are reflected in health and disability service priorities and allocation of finite health resources.

Furthermore, international experience suggests consumer representation does not guarantee consumer participation.  

**Managing the participation process**

Publicly-funded organisations must consider three important aspects when looking at participation programmes:

• it is important not to raise expectations by presenting participation as a panacea for all sector tensions, whether caused by resources or relationships

• meaningful participation is hard to achieve. Processes must not be seen as cosmetic, action must follow participation and real efforts must be made to ensure a balance between different groups' wishes and the realities of limited resources

• participation is costly and the benefits of programmes must outweigh their costs.

**Recommendations**

We recommend to the Ministers that:

(a) Responsibility for ensuring communities' values and preferences be reflected in decision-making, and that for consultation and communication, rests with the funder and providers in the context of their respective roles

(b) Communities have the right to participate in the publicly-funded health and disability sector

(c) Contracts between the Minister of Health and the funder, and the funder and providers, require them to show how they have reflected community and service users' values and preferences in their decision-making processes

(d) Publicly-funded organisations be encouraged to disclose and communicate as much information as feasible to communities and individuals

(e) Governments and their agencies recognise the value of affirmative action to encourage participation from communities with particular interests.

CHAPTER 10
Implementing the Change

Introduction

Further work is needed to implement the Coalition Agreement on Health proposals and those in this report. As required by our terms of reference we here outline:

- communication and consultation strategies
- the timetable and work programme for implementation
- the legislative programme
- the risks and risk management strategies to be adopted
- fiscal implications of the changes.

Consultation and communication strategies

This report has been called for by the Ministers and, once we have delivered it, communicating the report and the nature of any further consultation is a matter for them to decide. However, our terms of reference specifically request advice on communication and consultation strategies for any changes the Government may implement as a result of this report. Also, our own contacts with the health and disability sector over the past two months lead us to believe there would be considerable benefit in its early release.

We are conscious of how important consultation is, and agreed with the Ministers that our task could not include extensive sector consultation because of its short time frame. Instead we were invited to use our personal networks for expert input.

That process leads us to believe four important factors should underpin any communication programme:

- from our contact with the sector we believe it will support the principles underlying our recommendations
- the sector will want to know the Government's actions in response to this report
- the Government should be clear about further consultation on this report
- public confidence rests largely on sector confidence. The sector is cynical about over-promotion of health policy. In the interests of maintaining credibility and not raising unreasonable expectations of the extent of change likely in the medium term, we suggest communication mirrors the 'evolution not revolution' theme of this report.

The timetable and work programme for implementation

Policy work and Government decisions on agency roles must be completed by March 1998, or earlier for work with legislative implications, so new arrangements can be in place by 1 July 1998 as required by the Coalition Agreement.

We suggest the policy work programme be developed according to the following project categories:

- operating environment for the funder
- operating environment for Crown-owned providers
• information
• framework for disability support services
• funding issues.

These project areas are outlined in this chapter. There should also be policy development for the improvement of Mãori health, centering on:

• accelerating development of Mãori providers and the Mãori health and disability workforce
• ensuring a strategic framework for Mãori health and independence improvement
• aligning Mãori health and independence development with Mãori development per se.

We also note the importance of longer term work, which should be led by the Ministry of Health, on developing the regulatory framework for safety/quality, and on how medical education and specialisation may best be developed to meet future needs. These latter areas are two aspects of workforce development, which is a key part of the sector's infrastructure. While we do not advocate a return to workforce planning, articulating the Government's objectives for the health and disability sector workforce would give much needed direction to the funder, providers and education agencies who make operational decisions.

OPERATING ENVIRONMENT FOR THE FUNDER

The Government will have to make policy decisions on the function and form of the funder. These decisions will have legislative implications and should be made by August 1997.

Other decisions, which should be made by March 1998, or earlier if they have legislative implications, include accountability arrangements, structure of appropriations, future organisation for RHA subsidiaries, and Government requirements on structure of the funder.

OPERATING ENVIRONMENT FOR CROWN-OWNED PROVIDERS

Issues to be considered by the Government include:

• statutory objectives
• options for capital structure
• options for co-ordination across Crown-owned providers
• incentives and accountabilities for performance
• number and configurations
• approaches to capital investment.

Decisions should be made by March 1998, or earlier if legislative change is required.

INFORMATION ISSUES

The Coalition Agreement signals a desire to enhance public accountability. Community participation in the health and disability sector must be underpinned by free and open access to information. This becomes increasingly important with the development of new and diverse arrangements for integrated care. Information-related issues include:
• regulation or other mechanisms to ensure information disclosure
• compatibility of information systems and information requirements
• ownership arrangements for NZHIS.

The first step will be for officials to identify those issues needing immediate attention.

POLICY FRAMEWORK FOR DISABILITY SUPPORT SERVICES

Policy development should centre on methods for:
• increasing flexibility for the role of the agent
• empowerment of service users
• better integration of services.

This is medium term work which will extend beyond 1997/98.

FUNDING ISSUES

These include:
• ensuring service expectations and overall funding level and funding path are aligned
• capital structure in Crown-owned providers
• options for removal of deficit support in Crown-owned providers.

We know work has already begun in these areas. It is critical that it continue and maintain momentum so a consistent, robust funding/financing strategy is agreed. This will be a precondition for successful implementation of sector change.

The legislative programme

The Government should decide, in the light of policy work already outlined, if new legislation is needed or whether changes can be brought about by modifying existing law.

The Health and Disability Services Act 1993 will have to be changed. There will also be a need for minor, consequential amendment to the Hospitals Act, Health Act, ARCI Act, the Commerce Act and possibly other Acts.

The timetable is tight, as policy decisions with legislative implications will have to be made by 1 August to allow a Bill to be introduced by 30 September 1997. The Steering Group considers that, in developing new or amended legislation, the flexibility of current legislation should be maintained so new arrangements can evolve to meet needs.

The risks and risk management strategies to be adopted

GENERAL RISKS

As noted at the outset, ‘solutions’ to problems in health and disability systems always generate further problems. We suggest improvements rather than solutions, and do so in the context of limited dollars to fund unlimited health and independence needs. Our proposals will help create an environment in which relationships and performance can improve, but our proposals have some risks.

We have so far in this report covered specific risks but there are general risks arising from our recommendations, as well as some which are always present.
• the impact on health and independence outcomes of other sector policies (for example, economic policy, housing, social welfare etc)

• the difficulty of acceptance by a sector suffering reform fatigue. People who have seen three reforms over the past 10 years will be cynical about proposals to improve relationships and involve them in decision-making

• given the central role of the funder, its performance and behaviour are critical to sector improvement. The funder has to be powerful enough to effect sector change, but we note again the difficulties of holding the funder to account

• community and health professional participation in the funder’s decisions is important, but again it is only realistic to expect a level of cynicism in the community and among health professionals about how meaningful their involvement will be

• the policy positions we have advanced for Crown-owned provider objectives, funder objectives and the relationship between various agencies, should go some way to improving sector performance, but:
  - there is still scope for lack of alignment in agencies’ objectives
  - most health policy ‘solutions’ contain perverse incentives that emerge eventually
  - policies need to be integrated and consistent, especially in relation to funding

• there is always a risk that, for whatever reasons, the Government is unable to control growth in sector expenditure. Because the Government uses capped funding as a policy instrument, loss of cost control in one part of the publicly-funded sector will have consequences for the rest. This in turn will impact on the objectives of and relationships between various parts, leading to an increase in risks noted already.

RISK MANAGEMENT

This report includes strategies to manage these risks through:
• incentives for providers to manage costs
• greater participation of providers and health professionals in planning service strategies
• closer alignment of objectives between funder and providers
• restoring the emphasis on health and independence gain and public service
• more opportunity for the funder to prioritise and change service delivery.

These are all necessary, but they will not be sufficient to manage the risks. The full benefits of these changes will not be realised unless the Government is realistic about the amount of funding needed, and the Government, the sector and the community are realistic about the number of services that can be delivered.

As a first step in managing these risks, the Government should:
• acknowledge at the Cabinet table the impact of other sectors and wider government policies on health and independence status and outcomes
• inform public and sector expectations. It is critical that the process of determining what services are to be purchased (or not) by the funder is open and transparent to the public, and debate on the level of funding clearly heard and argued. The goal
is public ownership and recognition of the starting point, that is, how much the country is willing to spend on health and disability services and what service provision or rationing is consistent with it.

- accept responsibility for funding levels and for providing stability and credibility of funding at a reasonably defensible level
- allow funder and providers as much authority as possible to let them develop local solutions to local problems within national frameworks. The corollary of this is to establish and maintain clear and consistent accountability mechanisms.

Beyond that, governments can make decisions which actively reinforce these principles. The key risk management strategies involve long term changes in behaviour. Cultural change of this kind depends on leadership from all sector agencies, with people understanding and committing to different ways of behaving and working together. Culture cannot be set by central decree, but Ministers (and officials) can play an important part in setting the framework within which cultural change can happen, by providing information and modelling relationships.

**Fiscal implications of the changes**

We believe the changes in roles and responsibilities in the sector that we have recommended can, in the light of the Coalition Agreement, be accommodated without incurring increased costs. Our proposals are for evolutionary development minimising short term costs of change. There are potentially opportunities to make savings through better co-ordinated and linked activity within the funder and between agencies, although as already noted, adopting a more relational approach to contracting may increase rather than reduce administrative costs.

Our proposals also raise some specific fiscal risks:

- our theme that lack of clarity about how resourcing ties in with health and disability needs, and what services taxpayers can expect from their tax dollars, may result in more pressure for increased health and disability services funding
- there are risks associated with repricing CHE services (deficit switch) to set up Crown-owned providers on a sound financial footing. These include:
  - impacts on the Crown's projected operating balance arising from revised business plans showing more moderate gains in performance in out-years
  - the re-emergence of deficits in out-years arising from poor cost control or failure to implement business plans, despite price increases
- changes to the capital structure of Crown-owned providers could have a significant impact on fiscal aggregates. This would depend on the financial structure finally adopted
- increasing CHE prices to cover the cost of capital will require increased funding to avoid service reductions. In principle, this may be returned to the Crown through interest, or capital charge payments (depending on the capital structure adopted). In practice it may be difficult to design a system that does this in a fiscally neutral manner over time.

This analysis is based on our recommendations. We have not considered the risks of options we have rejected. Nor have we considered the risks arising from no change, but we are conscious there will always be an underlying fiscal risk in the sector deriving from how efficiently it can manage resources within a budget cap. It is
essential the Government maintains momentum in developing a strategy to deal simultaneously with service expectations and overall funding levels and funding path, withdrawal of deficit support, and changes in capital structure and accountabilities in Crown-owned providers. This strategy is critical to the evolution of the cultures and behaviours which is the core of our recommendations.
Appendices

Appendix I  Terms of Reference
Appendix II  Coalition Agreement on Health
Appendix III Membership of the Steering Group
STEERING GROUP TO OVERSEE THE HEALTH AND DISABILITY SECTOR CHANGES: ROLE AND TERMS OF REFERENCE

Overview

A Steering Group is to be established to provide advice to Ministers on the policy requirements and implementation issues of the health and disability sector changes included in sections 2 (on changes to public providers) and 3 (on funding arrangements) of the Coalition Agreement for Health.

The Steering Group will be chaired by the Director-General of Health and will involve people with health and disability sector knowledge and backgrounds.

The convenor of a working group will act as a secretariat to the Steering Group and the working group will undertake the programme of work determined by the Steering Group to allow it to discharge its responsibilities.

Terms of Reference

The Steering Group will report to Ministers on the policy requirements and implementation issues of the health and disability sector changes in sections 2 (on changes to public providers) and 3 (on funding arrangements) of the Coalition Agreement for Health, including:

- the roles, relationships and accountability arrangements for the health and disability sector agencies including the Funder agency, publicly owned providers, ACC purchasing, and the Ministry of Health
- the future contracting arrangements between Funder and providers
- timetable for implementation
- the legislation required to implement the changes
- the risk management strategies to be adopted in implementing the changes
- communication and consultation strategies
- fiscal implications of the changes.

This advice will need to be preceded by a work programme detailing the policy areas being covered by the Steering Group (with specific milestones) and the method of consultation and
discussion to be adopted in reaching firm recommendations. This work programme is to be
constructed so that final advice from the Steering Group is provided by 16 May 1997.

The Director-General of Health will be chairing the Steering Group and directly responsible
and accountable to Ministers for the overall management of the reporting and associated
consultation required for implementation of the Government's direction for the health and
disability sector. The Director-General will be responsible for ensuring that consultation
occurs at a senior level with other central agencies.

The Steering Group will direct a working group, which will comprise a small core group of
analysts seconded from different Government agencies (with a capacity to second additional
expertise and commission work as required) and will be responsible to the Steering Group in
exercising its functions. The convenor of the working group will act as the secretariat to the
Steering Group. Both the Steering Group and working group will be serviced by the Ministry
of Health.

The Steering Group in undertaking its responsibilities will observe the Government's
statement that the health sector will be consulted on changes to current arrangements in
administration and legislation, governance and reporting. The objective is to have an
inclusive process that engages the sector with a view to maximising the ownership of the
result. The Steering Group will observe the following non-negotiable principles as laid out in
the Coalition Agreement:

I. Retaining the separation between the structure that replaces RHAs as funder and all
health service providers including CHES/Regional Hospital and Community Services,
IPAs, GPs, Disability Services, Rest homes etc.

II. Limiting bureaucracy where possible.

III. Removing the 'for profit focus' from the CHES but require them to work in a
businesslike fashion.

IV. Giving greater emphasis to health gain.

V. RHAs purchasing from providers on a competitive price volume basis will be replaced
with contractual funding agreements between the structure replacing RHAs and all
providers based on historic funding information and levels, benchmarking information,
changes in technology and comparative data to provide a cost effective health system
that delivers the maximum amount of health care to patients for the taxpayer funds
available.

VI. The structure replacing RHAs will undertake monitoring, auditing and reporting functions
to enhance health gain and financial accountability.
1 April 1997

Karen O Poutasi
Chairperson
Steering Group
Ministry of Health
PO Box 5013
WELLINGTON

Dear Karen

NOTICE OF AMENDMENT OF FUNCTIONS OF STEERING GROUP ON ROLES AND RELATIONSHIPS OF AGENCIES IN THE HEALTH SECTOR

Pursuant to section 46(2) of the Health and Disability Services Act 1993 (the Act), I notify the Steering Group (being a Committee appointed by me under section 46(1) of the Act), of the following amending clarification to its consultation obligations under the functions set out in the terms of reference originally notified to the Group.

I note that the Group members were chosen because of their relationship with various key parts of the health sector. I expect members to have used, and to continue to use, their own networks in the health sector to assist them to carry out their functions.

The Government will make decisions on any necessary consultation after your report is provided, noting that any legislation arising from your report will be subject to the Select Committee process of Parliament. This will allow interested parties to make submissions on the Government's proposals.

In relation to the direct responsibility and accountability of the Director-General to Ministers, I note that this relates only to the requirement to deliver the report by 31 May 1997.
If there are any inconsistencies between the functions set out in the terms of reference and the clarified functions in this notice, the clarified functions in this notice shall take precedence.

Yours sincerely

Bill English
Minister of Health
POLICY AREA: HEALTH

Monday, 9 December 1996 4.30pm

GENERAL POLICY DIRECTION

a) Government is committed to providing a flexible, modern, properly funded, accessible health service that meets changing public needs and expectations. The Coalition Government's health policy has the overriding goal of ensuring principles of public service replace commercial profit objectives for all publicly provided health and disability services.

b) The Coalition Partners are committed to publicly funded health care that encourages cooperation and collaboration rather than competition between health and disability services.

c) By July 1998 there will be one funding body separate from the Ministry of Health which will carry out functions determined after consultation with the health sector and a review of the current system.

d) Public health providers (CHE Services) will be required to function in a businesslike manner. The new focus will be on achieving health outcomes and improving the health status of the populations they serve. Private sector involvement in services usually provided by the public sector will be subject to criteria set by Government.

c) Every effort will be made to minimise disruption to the health sector by progressively introducing any changes to health service referred to in this document. In most circumstances current arrangements will continue until 1 July 1998 when new policies add legislation will be in place.

KEY POLICY INITIATIVES

1. General:

a) The Minister of Health will be responsible for the whole publicly funded health sector and the publicly owned health providers.

b) Vote Health funding will be increased. Extra funding will be available to reduce waiting times for hospital treatment. Guaranteed maximum waiting times for various procedures will be introduced.

c) Health and disability services for children will be boosted to ensure children receive the care and protection they need for the best possible start in life.
d) Equity of access to health and disability services across generations will be assured by removing income and asset testing for older people needing long stay geriatric public hospital care services and asset testing for long stay geriatric private hospital Care.

e) By 1999/2000 introduce an exemption of $100,000 on the family home on the income and asset test on rest home care for single people and for married couples where both are in care.

f) Increased resources will be made available to address major issues in delivery of mental health services.

g) In recognition of, Government's commitment to improving the status of Maori health, increased resources will be made available to provide Maori leadership within the health sector, and to enable the continuing growth and development of Maori health service provision by Maori.

2. Changes to CHE Health and Disability (Regional Hospital and Community) Service Provider:

a) replacing Crown Health Enterprises with Regional Hospital and Community Services which will deliver those services currently provided by CHES. They will report directly to the Minister of Health through the Ministry of Health.

b) Removing the competitive profit focus for Regional Hospital and Community Services, replacing it with a requirement to carry out its activity in a businesslike fashion. The principal goal will be achieving improved health outcomes to contribute to the health status of the populations they serve. Legislative and administrative arrangements that will achieve these goals will be completed during 1997.

c) A commitment will be demonstrated to publicly provided health and disability services, with long term contractual agreements with Regional Hospital and Community Services for a range of services with the intention of providing the maximum mount of health care to patients for the taxpayers' funds available. Services will cover the following range:

- community and rural health
- mental health
- Maori health
- dental health
- public health (including health protection and promotion)
- intellectual, age related, physical/sensory disability support services
- maternity (including pregnancy and childbirth services)
Wellchild services
A&E
Secondary/tertiary medical and surgical services diagnostic services

d) i) Publicly provided health and disability services are complemented by a wide range of non-government health service providers. Regional Hospital and Community Services may form joint ventures with these non-government providers or other Crown providers, working collaboratively with them, when this is consistent with health gain priorities and with the criteria in d ii).

ii) Current contractual arrangements involving the private sector in CHE based services will continue. However, any new joint venture, subcontracting or private work undertaken, or involvement by private companies in CHE based services will be limited. Private sector involvement must result in improvements as defined in health outcomes, pose no increase in financial risk to the Crown assessed over the next ten year period, and must be approved by the Minister of Health after consultation with Coalition Partners.

e) Regional Hospital and Community Services will be required to develop initiatives in partnership with Maori, which lead to demonstrable improvements in Maori health status.

f) The Coalition partners have agreed to make minor amendments to the Commerce Act as it relates to some parts of the Health sector.

g) Ensure accountability and performance of Regional Hospital and Community Services receive high priority in their funding agreements.

h) Review after consultation the number of Regional Hospital and Community Services adjusting service boundaries to the optimum configuration to achieve health outcome goals.

i) Elected community representation will be considered by a joint working party of Coalition MPs as to the most appropriate place for public representation in the health sector.

j) The health sector will be consulted on changes to current arrangements in administration and legislation, governance and reporting.

k) In the case of general practice any GP budget holding beyond GMS, primary laboratory and pharmaceutical budgets must result in improvements in defined health outcomes, pose no increase in fiscal risk to the Crown assessed over a ten year period, and must be approved by the Minister of Health after consultation with the Coalition Partners.
1) Reconsider the decision to unbundling ACC funding from CHEs for acute and some elective surgery.

3. Funding Arrangements:

a) By July 1998 there will be one funding body separate from the Ministry of Health which will carry out functions determined after consultation with the health sector and a review of the current system.

b) Public health services will no longer be competitively purchased by RHAS. Providers of public health services will be required to comply with stringent contractual funding agreements with clear health outcome goals.

c) A review of the most appropriate structure to carry out these changes in policy will be conducted and concluded by May 1997. The Coalition will consider all significant developments and agree on all aspects of implementation arising from the review.

d) Implementation of the changes necessary to meet the policy objectives will be completed by March 1998 in order to minimise the disruption to health services delivery to New Zealanders and to manage a smooth transition to the new arrangements.

The six principles below we agreed as non-negotiable:

I. Retaining the separation between the structure that replaces RHAs as funder and all health service providers including CHEs/Regional Hospital and Community Services, IPAS, GPs, Disability Services, rest homes etc.;

II. Limiting bureaucracy where possible;

III. Removing the 'for profit focus' from the CHEs but require them to work in a businesslike fashion.

IV. Giving greater emphasis to health gain.

V. RHA purchasing from providers on a competitive price volume basis will be replaced with contractual funding agreements between the structure replacing RHAs and all providers based on historic funding information and levels, benchmarking information, changes in technology and comparative data to provide a cost effective health system that delivers the maximum amount of healthcare to patients for the taxpayer funds available.

VI. The structure replacing RHAs will undertake monitoring, auditing and reporting functions to enhance health gain and financial accountability.

4. Increase health sector resources and remove financial barriers to people needing to access health and disability services including:
a) Increase baseline funding to Vote: Health after full consideration is given to the sustainable funding work being undertaken.

b) Increase the waiting time fund by $50M in 199718.

c) Establish guaranteed maximum waiting times for surgical and specialist treatment.

d) Remove hospital user part-charges.

e) Providing free doctors visits mid prescription medicines for children 5 years and under.

f) Remove income mid asset testing for long stay geriatric public hospital care services and asset testing for long stay geriatric private hospital care.

g) By 1999/2000 introduce an exemption of $100,000 on the family home on the income and asset test on rest home care for single people and for married couples where both are in care.

5. **Pilot a community based family health team approach for the delivery of some primary healthcare services by Regional Hospital and Community Services:**

   a) Regional Hospital and Community Services family health teams coordinate and in some instances integrate primary healthcare with the delivery of the following services:

   - community health
   - mental health
   - Maori health
   - dental health (including school dental services)
   - public health (including health protection and promotion)
   - intellectual, age related, physical/sensory disability support services
   - maternity (including pregnancy and childbirth services)
   - wellchild services
   - hospital secondary and tertiary services

   b) Family health teams will facilitate access for people needing hospital care taking responsibility for their transition through health and disability services. Family health teams will be involved in providing some child health and disability services. They will act as a referral agency for other child health service providers monitoring service delivery for at risk children.

6. **Maori Health**

   a) Development of competent Maori Health providers is a critical requirement to support improvements in Maori health status. The following initiatives will be undertaken:
I. accelerated development of the professional Maori workforce
II. development of administrative add organisational expertise
III. Maori leadership within the Ministry of Health with dedicated provider approval, monitoring and evaluation functions
IV. increased public health resources for Maori provider development both directly to Maori providers and with a service obligation of Regional Hospital and Community Services

b) referred Maori service providers who meet minimum standards as set by the Ministry will be funded to provide a comprehensive range of primary healthcare, community based health and disability services and identified secondary health and disability services.

7. Child Health
a) In order to ensure a greatly enhanced focus on the health and protection of children the Ministry of Health will be required to appoint a senior person whose responsibility it will be to oversee, coordinate, motivate and lead in the area of health gain priority areas, i.e.:

child health
Maori health
mental health (Commissioner and Director of Mental Health already in place)
waiting list/waiting times

These people will report to the Director-General and Minister on progress or the lack of it in these areas.

b) During 1997 all child health programmes currently in operation will be reviewed with a view to building on those that deliver the best health gain and improved family function thus reducing risk to children.

8. Mental Health
a) The recommendations of the Mason Report are to be fully funded and implemented.

LEGISLATIVE IMPLICATIONS OF THIS POLICY AGREEMENT
a) Significant amendments to Health and Disability Act.

b) Minor amendments to the Commerce Act as it relates to the health sector.
Fiscal Implications of this Policy Agreement:

Over and above current baselines

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<tr>
<td>Likely increase baseline funding based on current information</td>
<td>$156m</td>
<td>$291m</td>
<td>$490m</td>
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<tr>
<td>Additional resources for elective hospital treatment</td>
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<tr>
<td>Remove hospital user part-charges</td>
<td>$7m</td>
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<tr>
<td>Free doctor visits and prescription medicines for children five years and under</td>
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<td>Remove income and asset testing for continuing care in public and the asset test for private hospitals</td>
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<td>In 1999/2000 exempt house to $100,000</td>
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<td>$67m estimated</td>
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<td>Establish “safety net” child health and disability services</td>
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<tr>
<td>Māori health provider development</td>
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<tr>
<td>Additional mental health funding</td>
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### Steering Group Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Dr Karen Poutasi</td>
<td>Chair</td>
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<tr>
<td>Ms Bridget Allan</td>
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<td>Mr Gordon Davies</td>
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<td>Dr Peter Didsbury</td>
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<td>Professor Mason Durie</td>
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<td>Mr Graeme Edmond</td>
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<td>Dr Rosy Fenwicke</td>
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<td>Ms Bette Kill</td>
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<td>Dr Mark Matthews</td>
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<td>Mr Wayne McLean</td>
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<td>Dr Graham Scott</td>
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<td>Dr Branko Sijnja</td>
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<td>Ms Christine Tuffnell</td>
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