

# **From Cost to Sustainable Value**

**An Independent Review of Health  
Funding in New Zealand**

**Commissioned by the Director General of Health  
on 31 March 2015**

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## Executive Summary

Current funding and accountability arrangements work to perpetuate the status quo in healthcare when we know that significant changes in service mix and design are required to meet on-going changes in disease burden without creating unsustainable financial pressures that crowd out other social spending.

This Review proposes a different approach to the way governments should manage health funding to encourage these changes in service mix and design: one that is also better aligned with emerging trends in funding other social services. This alignment is important not only because the social determinants of health need to be given more weight in setting health priorities but also because health and disability spending should be making a greater contribution to improving wider social outcomes, like improved educational achievement and employment as well as reduced welfare dependency and crime.

Our suggested approach aims to shift the focus from compensating providers for the cost of providing existing services in existing ways, to rewarding providers for delivering more value to health consumers<sup>1</sup> from the available funds over time: i.e., from cost to sustainable value. This requires three big changes in approach to health funding:

1. Focus on results or outcomes of value to consumers: While a degree of universality is maintained, we are suggesting more funding be focused on meeting the different needs of individuals in different population segments (which reaches beyond targeting on income and health need).<sup>2</sup> More funding should follow the choices that informed individuals make or the preferences they express.
2. Take a longer-term and broader “investment approach” to defining value when that approach is likely to yield substantial benefits: This would involve investing in areas like prevention, early intervention and rehabilitation when that is most likely to substantially improve people’s lives, and generate large savings in health and broader social expenditure (e.g., education, welfare, and justice) further down the track.
3. Encourage stronger performance from funders and providers: Here we are suggesting tying funding more closely to plans, including District Health Board (DHB) plans, that deliver the best outcomes or results for these population segments and encouraging delivery that is as good as, or better than, planned (e.g., rather than compliance-driven planning combined with burdensome administrative mechanisms to keep DHBs on plan). This has funding and accountability focused on what needs to be delivered, rather than on how it is delivered (which is rightly the province of providers and their clinical staff).

This approach will be most effective when it is complemented by non-financial incentives and supported by changes in the structure and conduct of primary, community and secondary providers so they are better able to deliver truly integrated care. Indeed, the suggested changes in funding arrangements aim to encourage these changes in structure and conduct.

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<sup>1</sup> We use “consumers” to refer to the people served by the health system: either directly as patients and their families, or indirectly as those drawing comfort from knowing that the service is there if they need it. Funders fund providers to provide health services to consumers.

<sup>2</sup> The New Zealand Medical Association referred us to Marmot’s concept of “proportionate universality” which argues that “... actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage” (Fair Society: Healthy Lives). We are suggesting that this proportionality idea be extended (especially to prevention, rehabilitation and early intervention, where the future benefits in terms of people’s welfare and fiscal savings justify this additional investment).

The changes we are proposing aim to address three big problems that have undermined confidence in current funding arrangements: lack of transparency about the value being delivered; real concern about the sustainability of current funding arrangements; and a need to reduce persistent inequalities in health outcomes.

At the highest level we are suggesting the creation of four “pools” of funding covering:

1. Existing “foundation” services that are not picked up in the other three pools (including most universal services);
2. Immediate government priorities, like elective surgery and wait times;
3. Health investments, to encourage a change in service mix and design that will improve the financial sustainability of the public health system over time as well as improve outcomes for the individuals involved; and
4. Social investments, to encourage better integration of health, education, welfare and justice services to address complex problems of specific population segments that would have otherwise required substantial remedial social services over time.

These two investment pools would be made up of a number of specific “funds” that are defined by the high-level results they aim to achieve for a distinct population segment, such as: reduced hospitalisation and on-going health costs for those with long-term conditions; increased independence and employment for those on welfare as a result of sickness or disability; and better lifetime prospects for people suffering from mental health problems, especially children and youth where the lifetime payoff from early intervention is likely to be greatest. The investment approach is best applied in these two pools.

While application of the investment approach is well developed by the Accident Compensation Corporation for treatment of injury, this approach is not used at all in health for the treatment of sickness and disability. That means that the information and expertise required to operate a fully fledged investment approach are lacking (e.g., lack of actuarial information and expertise). We have, therefore, developed a funding model with 10 “generic” features that can be adapted to manage the funding process for each fund in this information- and expertise-poor context.

We are also recommending a change in the way plans from DHBs and others are solicited, assessed and funded to encourage them to produce the best plans they can and then deliver results that are as good as, or better than, those plans.<sup>3</sup> This contrasts with the current incentive to produce a compliant plan and to stay on plan in order to avoid escalation in central “monitoring” that reduces DHB discretion and adds compliance costs across the whole system.

A new step in this process is the “qualification” of DHBs and others to submit plans for funding from the various pools. The Ministry of Health, as agent of the government as funder, would qualify eligible entities on the basis of their ability to: provide a comprehensive and high-quality service to a segment of the population; manage the risk that desired outcomes would not be delivered; and measure progress toward these outcomes. The Ministry does this to some extent now with services provided via DHBs as well as with services directly funded by the Ministry. As now, many of these entities would own providers, and fund providers they do not own, in order to ensure a comprehensive service can be provided (i.e., like DHBs, many of these entities would have both

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<sup>3</sup> While governance and management will be influenced by a range of incentives (e.g., DHB boards will have an eye on re-election and re-appointment), we are concerned here about the incentives created by funding and associated accountability arrangements.

funding and provision roles). As now, DHBs are not to be the only entities eligible to submit plans for funding; however, the scope for other entities will be wider (especially in the investment pools and especially if DHBs do not have the capacity or capability to justify qualification or if subsequent performance proves inadequate).

One of the main reasons for the introduction of this “qualification” step is to encourage the development of service designs and associated service plans that are able to provide a fully integrated service: i.e., designs that pull together all of the providers necessary to deliver a service that is comprehensive and integrated enough to actually deliver the desired outcome or result. This should also encourage a more sophisticated approach to funding<sup>4</sup> when traditional approaches are less effective: i.e., one that encourages dialogue between funders, consumers and providers to cascade high-level results into the right mix of intermediate milestones and to stimulate innovative service design. That, in turn, should encourage the development of a more unified health system; one that is unified around the consumer, rather than a service or a provider, and so can play a bigger part in improving health and broader social outcomes.

Another key element of the new approach is to supplement changes in funding with changes in national pricing and in the way inter-district patient flows are managed to encourage a shift in service mix (from the current degree of reliance on hospital-based care toward primary and community care). DHBs are less likely to make these changes if they see investments in primary and community as adding to, rather than substituting for, hospital provision. This lack of substitution is most likely when hospital-based care is fully funded at average cost but where the marginal cost is low for long periods (most likely in DHBs with slow or no population growth).

Given the increased emphasis that needs to be placed on primary care, we are also suggesting changes to the way primary care is funded in order to improve access for those on low incomes and those with a particularly high need to access primary services. While this should help narrow disparities in health outcomes, access is not the only issue. In particular, there are a number of funding arrangements that incentivise providers to focus on the easier cases and under-serve the more difficult, harder to reach and less compliant ones. A greater focus on outcomes will go a long way to overcoming this problem, although there are also some specific funding mechanisms that we suggest need further attention (e.g., maternity services and aged care).

Given the size and scope of the funding changes we are proposing and the relative lack of existing capacity and capability in the sector to manage the suggested approach, we have suggested arrangements that allow for considerable latitude in managing the transition. There is a discussion of these transitional arrangements in each major section of the Review, as well as suggestions for how this might be operationalised in the 2016 budget process.

Apart from the lack of existing capacity and capability, the major risk we see in adopting our suggested approach is that it does not go far enough in creating the conditions to bring forward the necessary changes in service mix and design: i.e., those changes necessary to address the changes in disease burden we are confronting within a sustainable funding track. However, the next step is likely to involve structural changes in both the Ministry and the DHBs. That would be both disruptive and distracting, so cannot be taken lightly.

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<sup>4</sup> We use the term “funding” broadly to cover commissioning, purchasing and contracting: i.e., all more or less active and/or sophisticated forms of funding services.

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# 1 Purpose

The purpose of this Review is to suggest how government's funding of health can be changed to: make more transparent what value is being delivered from that funding; encourage more attention on controlling future health costs; and help reduce inequalities in health outcomes. The focus is on how government manages its budget and funding process to better meet these objectives.

## 2 Context and Approach

Funding plays a large part in determining what services are provided, how they are provided and who receives them. That is why funding decisions are typically controversial. While non-financial motivations are important, the ingenuity, effort and investment devoted to doing the right thing will be diluted if funding signals are not supportive.

In shifting focus from cost to sustainable value, we need to take a balanced approach to value: one that recognises an appropriate expression of all three legs of the Institute for Healthcare Improvement's Triple Aim: improving the patient's experience of care; improving the health of populations; and reducing the per capita cost of care.

### 2.1 Non-financial incentives are important

Funding works by influencing the behaviour of both the consumer and the provider of health services and so works better when it is aligned with their non-financial motivations. In some cases, it will be hard to get the financial incentives right and aligning non-financial incentives to encourage the desired changes in provider and consumer behaviour will be more effective. Indeed, one of the attractions of the recent work on the Integrated Performance Improvement Framework (IPIF) has been its emphasis on engaging with providers to identify a set of non-financial incentives that are meaningful to them and can be aligned to deliver better outcomes. That work should be progressed.<sup>5</sup>

### 2.2 More focus on outcomes and on population segments

Greater transparency of the value being delivered requires a greater focus on funding the results that are important to consumers, rather than on compensating providers for the cost of providing existing services in existing ways, because cost is becoming a less useful proxy of value. This applies as much to the universal services delivered by District Health Boards (DHBs) as it does to the need to focus more heavily on population segments with low incomes, high health needs, poor health outcomes or where investment in prevention, early intervention and rehabilitation will produce significant benefits over the longer term. In terms of universal services funded on a population basis via DHBs, for example, more attention needs to be given to the patient experience, to service quality and to results for different population segments within a district. Because DHB districts are aggregations of Statistics New Zealand "mesh block" data, for example, it is possible to identify communities within a district where these results are not satisfactory and, therefore, focus more attention on these communities. Better targeting of investments in prevention, early intervention and rehabilitation that will reduce the need for more care, and more expensive care, later in life will also help improve the sustainability of the public health system.

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<sup>5</sup> IPIF in its current format is strategically sound, but needs to be completed so that the incentives matrix can be transformed from an activity to an outcome focus.

## 2.3 A sophisticated funding approach is often required

Different funding mechanisms are suitable for different situations.

When the link between an activity and a valued outcome is well known by the funder in advance and more of the activity is desired, it is often simpler and easier to fund the activity directly. Funding for additional elective volumes has been structured on this basis and has been very successful in generating more electives. Fee-for-service payments have the obvious effect of encouraging more of the service that attracts the fee. However, this is not the right approach when more of the service generates more cost without a commensurate improvement in outcomes. Capitation payments that follow the choices consumers make can encourage providers to be more consumer-centric, but requires consumers to be well informed and have some choice: i.e., effective competition for consumers. If this is missing, and if capitation is simply paid on enrolment, then capitation creates an incentive to enrol more patients and reduce the cost to serve them (and some of this reduced cost is counterproductive). All of these approaches are relatively simple to administer in relatively straightforward situations.

Tying funding more closely to outcomes is attractive but can be more difficult and expensive to administer, especially when outcomes are hard to measure or take a while to achieve, or when it is not clear what needs to be done to achieve them. High-level health, education, employment and/or crime prevention outcomes need to be well defined and may also need to be cascaded into intermediate-level results and milestones. When it is not clear what is required to deliver outcomes, then it is important that the risk of non-delivery be assigned to those who can influence the result as well as those who can spread the risk (rather than leave all the risk to be borne by consumers and taxpayers by default).

In the most complex cases it is better to engage consumers and providers (including clinicians) in a dialogue about the mix of intermediate results and milestones that are most likely to deliver the desired high-level outcome and the service mix and design that are most likely to produce those results. This requires that providers are able to deliver the full range of services needed to produce the desired high-level outcomes and that they share some of the risk that this outcome may not be delivered, despite everyone's best intentions.

In these cases, the funder effectively selects the best set of partners to work with to achieve a high-level result. This requires a new step in the funding process: one that pre-qualifies the parties able to submit plans for funding. Given that these parties have to be able to deliver a comprehensive and well-integrated service, this also helps unify service delivery when that unity matters most.

This approach can accommodate a variety of arrangements; from relatively straightforward arms-length funding arrangements through to more complex alliances and joint venture arrangements. When necessary, it encourages funders and providers to work with consumers to find out what they value; to engage clinicians in better defining quality dimensions; and then to encourage providers to come up with service designs that bring together the required range of services and service providers that are most likely to deliver that value. This is quite different to a funder trying to second guess in advance the sort of indicators, activities, services or service designs that should be funded.

This suggests an approach that is much closer to the sort of true alliance contracting that we see public funders adopt in other sectors (e.g., in contracting for some road construction and highway maintenance) and are starting to see adopted by some DHB funders of health services. Really successful alliances will behave more like a joint venture – with shared goals, shared risk and at

times even a distinct legal persona with its own staff – than the typical arms-length funder–provider relationship.

## **2.4 An investment approach is applicable in some cases**

Our approach also draws on the experience of the Accident Compensation Corporation (ACC) in applying an investment approach to funding health services. In ACC’s case, early investment in rehabilitation following injury is justified by reduced medical costs and earnings-related compensation further down the track. It is also better for the client.

This approach is not applicable everywhere in health. For example, some prevention and early interventions may end up adding to cost as people live longer with on-going health problems. There is no suggestion that this activity be reduced. Indeed, by investing more in prevention, early intervention and rehabilitation when that also reduces future cost, there is less cost pressure over time on those health and social services that do not generate savings.

We propose using an investment approach when earlier investment would yield significant personal and fiscal benefits over a person’s lifetime, in terms of either reduced future health costs or reduced costs across the social sector (especially welfare, education and justice). We describe a “generic” funding process that can be applied when the conditions for a fully fledged ACC approach are absent.

## **2.5 Transitional arrangements need to allow for learning and capability development**

We are proposing a gradual and managed transition to the proposed new funding approach, with some attention to the implications for health funding in 2016. These proposed changes will take a bit of getting used to, so both funders and providers will need time to adapt and to build capability and capacity. The contemporaneous review of capacity and capability should help identify what needs to be done in greater detail. It also reflects the fact that current approaches to funding have encouraged quite a fragmented primary and community sector and that changes in funding will encourage changes in the structure and conduct of this sector so that it is better placed to play a bigger role in tackling the changing disease burden we face. That change will take time. Moreover, a gradual transition also reflects the fact that the approach suggested here will require refinement as lessons are learned in its application.

# **3 Background**

In recent history, Ministers have been guided in their determination of the right quantum of funding for public health services by a sense of what is required to maintain and expand existing services, given population and cost pressures: i.e., the “demographic/cost” approach. A little over 70% of that funding is then distributed as operating expenditure to 20 District Health Boards (DHBs) on the basis of the Population-Based Funding Formula (PBFF). DHBs are charged with improving the health of their local population and reducing disparities in health outcomes. The Ministry spends most of the rest of the money on funding health and disability services directly, rather than via DHBs.

# **4 The Challenge**

This approach to funding is coming under increasing pressure from three forces: lack of transparency; concerns about sustainability; and difficulty tackling long-standing inequalities. All of these problems are aggravated by a health and broader social sector that is overly fragmented, so

funding changes should also encourage effective collaboration amongst all those required to deliver the comprehensive and well-integrated set of services when that is necessary to achieve a high-level outcome.

#### **4.1 The need for greater transparency to support better investment and prioritisation**

Currently, it is not clear what results are being produced for the money spent and, therefore, where re-prioritisation or additional investment would yield a better result. With a few exceptions, DHBs and the Ministry of Health are both funded to provide a universal service to either a district- or a nation-wide population. Aggregate population-level results, like length of life, incidence of disease and distribution of these outcomes across different groups, can be measured and compared with other jurisdictions. However, results at this very general level do not provide a sufficient basis for setting priorities or making investments either within health or across the wider social sector. A more granular approach would be more useful, with funding more closely tied to outcomes for different population segments.

##### **4.1.1 Funding results**

We know a lot about cost and activity because these factors drive funding (e.g., cost-weighted demographic funding, capitation and fee-for-service). Conversely, we know very little about the benefits of all this activity, in part because we typically do not fund results. This makes it hard to make sensible investment and prioritisation decisions and focuses accountability on how things are done rather than the results produced.

Funding would be more effective if it were targeted on results/outcomes for consumers, giving providers more scope to deliver those results in innovative ways (a “tight (on specifying result); loose (on specifying how that result should be achieved); tight (on accountability for delivery)” approach to funding).

Even when it is difficult for funders to tightly specify a result *ex ante*, it is possible for them to identify the sort of high-level outcomes they are looking to achieve and work with providers to identify innovative ways of achieving them, with an agreed set of indicators and milestones to measure progress (as well-functioning alliances can do).

##### **4.1.2 An investment approach that supports earlier intervention**

Funding can also be better matched to return: i.e., proportionately more funding on those population segments where early intervention will have the greatest positive impact over the lifetimes of people in those segments. Here an investment approach is required: i.e., one that estimates the actuarial cost of a lifetime of publicly funded remedial interventions and sees that as the return on investing more public money in earlier intervention. ACC manages its future claims liability on this basis: i.e., investment in rehabilitation is justified on the basis of reduced future claims on the relevant ACC fund.

###### *a. When the benefits are produced and captured within health*

This is easier when the interventions required to produce a result are largely health-related and the benefits of prevention, early intervention and rehabilitation are fully captured within the health system. For example, many DHBs have some measure of success in funding primary and community care to better manage long-term conditions and so reduce hospitalisations. However, they are not supported by current funding arrangements that make it hard to realise the gains from reduced hospitalisation (especially in slow-growing regions), and only provide weak incentives on DHBs to consider the longer-term implications of today’s decisions (see section 4.2). These issues need to be

addressed and a more sophisticated investment approach developed: e.g., one that is better informed by an individual's likely risk of hospitalisation and the associated benefits of reduced hospitalisation over the person's lifetime.

*b. When the benefits are produced and/or captured across the publicly funded social sector*

There is also considerable potential in better matching investment to return when the benefits accrue across a wider set of social services, like welfare, education and justice, and/or the interventions required to produce these benefits span health and these other agencies.

In the former case, DHBs and the Ministry of Health are unlikely to invest enough in these interventions because the benefits accrue elsewhere. Welfare payments, for example, generate on-going liabilities for the Crown (as income-related compensation does for ACC) and yet this is typically ignored in deciding where to invest health funding.

Better matching investment to the benefits of that investment requires the actuarial value of all the public benefits to be estimated and pooled, if only virtually (i.e., reduced welfare dependence, increased employment, and reduced crime over a person's lifetime need to be taken into account in deciding how much to invest).

Appropriating to departments to only provide elements of a comprehensive service makes it hard to tailor solutions to the needs of individuals or sub-populations (e.g., improving mental health outcomes is likely to involve employment, housing and social support as well as some medical intervention). It will always be a frustrating task for navigators to try to pick and mix existing generic departmental service offerings to meet individual needs. It is better to design service offerings around common patient needs (and the mix of services necessary to meet these needs) and use case management when that is necessary.

## 4.2 Concerns about sustainability

### 4.2.1 Service mix and design have to change to meet future demand

In the last few years DHBs have been much better at maintaining and expanding existing services within the per capita cost-adjusted funding they have received; operating deficits have been reduced at the same time as new funding has been reduced.

However, we know that future demand for health services will be very different and the existing DHB service mix and service models will have to change. There is little confidence that the sector is reconfiguring itself fast enough to meet the likely increase in demand from the growth in chronic and long-term conditions without substantial pressure on real per capita spending: i.e., it is unlikely to keep living within the means provided by the current demographic/cost funding approach. For example, Health Workforce New Zealand has designed new service models for a number of services in order to respond to a future where the growth in demand significantly outstrips the growth in available funding. These models, and the workforce required to support them, are quite different to current models or, put another way, continuing to meet increased demand with current service models would require a substantial increase in real per capita funding.

### 4.2.2 Current funding frustrates adjustment

Indeed, current funding and associated accountability arrangements do little to encourage the sort of changes required and, if anything, tend to perpetuate health's episodic- and treatment-based service mix and the hospital-based and the provider-centric operating model that supports it.

DHBs have a lot invested in hospital capacity and find it almost impossible to reduce that capacity, typically because of local resistance. Unless their populations are growing, the marginal cost of hospital services can be relatively low and spending more on primary and community care is as likely to add to total cost as it is to substitute for more expensive hospital care, at least in the short term. DHBs have every incentive to take a local, short-term view because the future consequences of this view will inevitably be borne by future taxpayers, via deficit funding, rather than come at the expense of local services. In short, the way DHBs are funded encourages them to fund a service mix that under-invests in those services that would better address emerging demand: i.e., to favour hospital care and under-invest in prevention, early intervention, long-term condition management, rehabilitation and end of life care.

#### 4.2.3 Current funding does not encourage innovation

The health system is also slow to adapt to the changing service demands facing it because there is little incentive for successful innovation to be picked up and to spread. Local innovation occurs but often remains local, and even successful innovation may not outlast pilot funding. Funding needs to encourage the widespread uptake of successful innovation.<sup>6</sup>

While there may be a place for a separate innovation fund, this does not really address the main issue: i.e., lack of adoption of innovations that have been shown to work. Addressing the issue relies on the wider incentive environment discussed below. If an innovation fund were contemplated, it would need to address the adoption issue (e.g., by only funding proposals where sufficient numbers of providers agree in advance to adopt the innovation should it prove successful).

##### *a. In the hospital setting*

In the hospital setting, “tight-loose-tight” funding would at least allow more scope and more reward for local innovation. Changing the way inter-district flows (IDFs) are funded and managed would give more patient choice and help strengthen the financial rewards of being more efficient and responsive (see section 9.2.3).

##### *b. In the primary and community setting*

However, it is primary and community providers, along with patients and their families, who will have to play the major role in meeting the expected increase in demand from chronic and long-term conditions. This is the area where innovation and adaptation are most important and where informed consumer and referrer choice can play a much more powerful role.

That requires funding to follow the choices of patients and referrers. These decisions also need to be better informed by information about the results achieved by different providers. This requires people having a degree of choice amongst providers who are capable of delivering a result, rather than contributing only elements of an overall solution (i.e., specific capacity (e.g., beds) or specialist activity (e.g., counselling, medical treatment or job placement)), typically leaving consumers and future taxpayers with all of the risk that the sum of these elements do not produce the desired result.

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<sup>6</sup> Our review indicates that the barriers to the successful development and broad uptake of innovations in healthcare in New Zealand include: the nature of many models of care, which are provider-centric and in which consumers are passive; shortfalls in health system and clinician leadership; inadequate health system intelligence; problems in the structure of New Zealand’s health system; restrictive regulatory practices and the threat of litigation; territorial behaviour by professional guilds; and, most importantly, poorly constructed business models and often perverse funding and remuneration systems.

If funding follows the patient, then those provider entities that deliver better results for patients will attract more funding. That will create a strong incentive on providers to be responsive to what patients really need and to deliver more and better service for the available funding. Not only would more people get better service but there would be a stronger incentive on providers to innovate and for that innovation to be taken up by others.

Provider-centric funding spread across numerous specialist providers frustrates patient choice and makes it harder than it needs to be to design service models and tailor services to meet the needs of individuals and different population segments. Separately funding primary health organisations (PHOs), DHBs and a myriad of relatively small non-governmental organisations (NGOs) to only provide a part of the overall service required undermines the capacity of the primary and community sector to take accountability for delivering results.

Moreover, annual contracts do not create the longer-term certainty required for private providers to invest in infrastructure or other assets required to develop a more capable primary and community sector. Trying to address this issue by spending tens of millions each year on “provider development” is a poor substitute. It is better to set a longer rolling funding term that gives providers more revenue certainty and therefore the confidence to make their own investments, than to have officials trying to decide who should receive development money and what sort of development they should do. Business owners will be both better informed and better incentivised to make the right choices on what are essentially business ownership decisions.

While longer terms might lock in poor performers, their revenues would not be increased beyond the contracted amount and the contract term would gradually shrink if they did not improve. That is likely to be a more effective spur to performance improvement than handing out development subsidies. Even if this incentive fails, it might be cheaper to pay out poor performing contracts than continue to sink development money into poor performers in the hope they will come right.

While newly formed alliances between primary and community providers and DHBs can potentially create provider entities that can put together all the elements of a service required to deliver results, the effectiveness of the current alliances are highly variable and all need strengthening. Similarly, NGOs need to be encouraged to join or form alliances, amalgamate or contract amongst themselves to form aggregating entities that are capable of providing a comprehensive service offering and managing the financial risks associated with being rewarded for results.

In more remote regions where there may only be a single provider capable of delivering a comprehensive service (e.g., a DHB alliance), then patient choice cannot drive the allocation of funding. In these cases, some element of funding will need to be conditional on delivering better results, including an improved patient experience. To ensure that the provider in these regions is held to a similar standard to those in more populated areas, their performance could be benchmarked against the results delivered in regions where consumers had choice.

#### **4.2.4 Implications for future funding**

These considerations have a number of implications for the way we should fund health to improve sustainability. Funding needs to encourage a shift in service mix from hospital care towards prevention, early intervention, long-term condition management, rehabilitation and end of life care (e.g., by preventing avoidable hospital admissions and readmissions and reducing length of stay). Funding also needs to encourage a change in service model design to allow expected demand growth to be met without creating pressure on real per capita spending. This change in service mix and design needs to be supported by a community-based and patient-centric operating model and

complemented by better targeting on those groups where lifetime benefits of early intervention are highest. Funding also needs to make it easier for DHBs with slow or no population growth to make this switch without simply adding to cost.

### **4.3 Inequities**

#### **4.3.1 Population-based funding is less and less useful as a proxy for need**

Population-based funding tries to match funding to need by varying the quantum of funding based on the size and demographic characteristics of the population (e.g., using population size, age, sex, ethnicity and socio-economic status as proxies for health need). The aim is to redistribute funding amongst DHBs over time to move them closer to what they should get based on the needs of the population they serve.

However, the desire to match funding to need at the geographical level is being frustrated by the desire to maintain current service and operating models: i.e., by funding cost rather than need. For example, the practice of setting a minimum increase in funding for each DHB means that some DHBs continue to receive a higher level of funding than justified on the basis of the population-based funding formula.

As more weight is given to trying to protect the status quo (e.g., with minimum allocations to slow-growing DHBs, by adding “adjusters” to the PBFF to reflect actual cost to serve and by calculating national prices that reflect average costs of existing service models), the process becomes less transparent and less legitimate as a population-based funding mechanism that is supposed to reflect need. At some point, what started out as population-based funding to reflect need ends up with a formula that accommodates and reflects whatever the actual cost of existing services happens to be.

Current population-based funding recognises that some population segments, like age and ethnicity, deserve more weight because their needs are higher. What we are suggesting is a much more refined approach to population segmentation based on both current and likely future need.

#### **4.3.2 Current funding arrangements do not help to reduce disparities**

Many of the current national and local funding arrangements also undermine progress in dealing with long-standing disparities in health outcomes.

National funding can be much better targeted to improve access to primary healthcare. Capitation funding and the various funding streams layered on top of it, like Very Low Cost Access, should be redesigned to provide better support to those on low incomes and those with high health needs, and to address the key issues currently inhibiting access – all without costing more.

Many current funding arrangements at both national and local levels also encourage providers to focus on easier cases and under-serve those who are hard to reach or expensive to serve. For example, capitation payments, population-wide coverage targets and fixed fee schedules all have this feature. Funding needs to encourage more attention on the harder cases when the return to successful intervention is greatest.

Finally, funding encourages responsive, treatment-based care rather than early detection and proactive management of population segments with highest health risk.

#### **4.3.3 Maori will benefit most from change**

Maori and other population segments whose health outcomes are poorer than the rest of the population will gain the most from the changes we are proposing.

These are the people who will benefit most from better targeting of support to make access easier for those on low incomes and/or with high health need. They are also the people who will benefit most from changes in funding that encourage providers to focus more attention, both quantitatively and qualitatively,<sup>7</sup> on those who are hard to reach and expensive to serve, rather than on groups with the converse characteristics. They are also the people who tend to suffer the most later in life because their health problems were not detected and treated early enough and/or their chronic conditions are poorly managed in the community setting. Better access, more outreach, earlier detection and treatment of high-risk groups, and better management of chronic conditions in the community are most likely to benefit most those, including Maori, whose current health outcomes are relatively poor.

Finally, there are a number of people with poor health outcomes who also have poor education and employment outcomes and have more interaction with the justice sector (including as victims of crime). It is specifically these people that will benefit the most from earlier investment to improve health, educational and employment outcomes and reduce on-going cost to the Crown of welfare and crime.

## **5 A Desire for Change**

This pressure on current funding arrangements is creating a desire for significant change in funding approach from a number of sources.

### **5.1 Ministers want more transparency and greater assurance on sustainability**

Ministers are looking for more assurance around funding sustainability and more transparency in order to make better funding decisions within health and across the wider social sector (health, education, welfare, housing and justice). The fact that DHB funding is decided early in the budget process, and has first claim on health spending, limits the extent of reprioritisation across the social sector on the one hand and between DHBs and Ministry spending on services, like disability, on the other (even when non-DHB spend might result in better health outcomes). Implicitly, where funding is on a demographic/cost basis with most appropriations to individual DHBs and the only influence over how the funding is used is limited to approval of DHBs' annual plans, it does not provide sufficient transparency or assurance over sustainability.

### **5.2 DHBs feel hamstrung**

DHBs feel overly constrained in their ability to respond to the changing pressures they face because the focus of accountability is too heavily skewed to how things are done rather than results. They face real resistance to changing existing services, and in some cases even changing service provider, and in closing facilities that are clinically and financially hard to sustain. Moreover, their funding discretion is limited by the likes of national contracts and ring-fenced funding. DHBs would prefer clarity and accountability around expected results in order to have much more flexibility around how they deliver these results. This is likely to require their funding to be more closely aligned to the delivery of specific sets of results.

### **5.3 Primary and community providers are frustrated**

Primary and community care providers know that they need to play a bigger role if we are to successfully meet the challenges posed by the changing disease burden and yet see funding as

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<sup>7</sup> In regard to the cultural basis on which communities are engaged and services delivered.

helping to perpetuate the status quo (e.g., they see the first call on DHB funding typically aimed at protecting existing investments in DHB provider arms). Meanwhile, funding numerous small and very specialised providers fragments community-based provision; short-term contracts make investment in capacity building much riskier than it needs to be; and funding activity rather than better outcomes for clients all conspire to undermine the sector's ability to deliver the sort of comprehensive service offering necessary to improve results.

## 6 Transition to a Different Approach to Funding Is Required

The current approach to funding is unlikely to be sustainable; resists reprioritisation and investment that is likely to yield better results; and is drifting away from its original rationale of funding DHBs on population need while letting them figure out how best to improve the health of the local population and reduce disparities in health outcomes. Any new approach to funding has to be able to improve transparency with more of a results orientation; better match investment to likely return; improve sustainability; and reduce inequalities.

Addressing these concerns requires a different approach to funding health and associated social services, one that has the features discussed in section 4 above. For most of the proposed changes, it will take some time for funders in the DHBs, in the Ministry/National Health Board (NHB) and in other agencies to develop the skill to manage the suggested funding approach. Ultimately, it may require new institutions (as the Productivity Commission is considering in its *More Effective Social Services* draft report, p. 21). It will also require change in the structure and conduct of providers as well as development of clinically supported results measures and better information to guide referrers and consumers.

All that suggests the desirability of a phased transition to the new arrangements. While a concentrated effort is required, we should take some comfort from the fact that ACC has had many years of successfully applying an investment approach to managing health issues. That is the most novel change that we are proposing and we know from ACC's experience that this approach works for certain health services and we know how to make it work.

After a brief overview of the current funding arrangements, the rest of this Review describes the proposed new funding arrangements and suggests how the transition to them might best be managed.

## 7 Current Arrangements

### 7.1 Current Vote structure

Vote Health is divided into three high-level appropriation groups:

1. Departmental operating expenditure (a little over 1% of the Vote), of which about 45% is spent on a combination of managing purchasing and sector planning and performance monitoring (largely of DHBs);
2. Non-departmental operating expenditure (about 92% of the Vote), of which over 80% is used to fund health services from DHBs, with each DHB having its own appropriation. The rest is used by the Ministry to purchase services directly, rather than via DHBs (largely disability but also workforce, child health, electives, maternity, primary health, public health, some mental and personal health and so on); and

3. Capital expenditure (about 7% of the Vote), which is almost entirely used to fund DHB capital expenditure that is not met by the DHBs themselves.

Disability aside, the bulk of health spending ends up with DHBs as operating or capital expenditure or is used to administer the funding and monitoring of DHBs.

## 7.2 Current budget process

DHBs are given a funding signal very early in the national budget setting process so that they can prepare their annual plans for approval by the Ministers of Health and Finance. The overall size of budget allocation to the social sector and to Vote Health is then decided as part of the national budget process, effectively giving DHBs first call on those elements of the social sector budget that are not demand driven and all of the remainder of the health budget, including Ministry spending directly on disability and health services. Given a very natural bias amongst DHBs to protect their investment in their provider arms, this process effectively gives their hospitals first call on the extra money available to social and health services at a time when we know that hospital-based care is not the best way of managing the growth in chronic and long-term conditions.

The overall quantum to be allocated to DHBs is decided by Ministers, largely on the basis of what is needed to meet the cost of funding existing services, less something for estimated productivity gains plus something for any new initiatives that have to be provided by DHBs. The quantum is then distributed to DHBs via the PBFF.

## 7.3 DHB planning and budget approval

DHBs prepare an annual plan that describes how their allocated budget will be spent to deliver existing services and meet national, regional and local priorities, without running unacceptable deficits. Each DHB's plan and budget are then approved at the same time by Ministers.

There is no funding incentive to prepare a better plan and typically no funding made contingent on DHBs delivering planned milestones. Instead, the incentive on DHBs to deliver their annual plan is largely created administratively: DHBs who under-perform on the financial or clinical aspects of their plans are subject to increased monitoring, which effectively means less managerial autonomy and a greater administrative burden.

One case where funding has been made contingent on performance has been remarkably successful: i.e., elective surgery. Each year the government sets targets for additional elective discharges, which are part funded by the Ministry at average prices. In this case, money will be withheld if individual DHBs – or the region they are part of – do not meet their elective discharge targets. Interestingly, DHBs have tended to over-perform in the delivery of their elective targets under this funding arrangement every year but had serially under-performed previously when they were just expected to fund an increase in electives in line with population growth out of their PBFF (even when new funding allocated under the PBFF was higher than it is today).

# 8 Overview of Proposed Arrangements and Transition

The current arrangements are heavily focused on maintaining existing services produced in existing ways. Quite a different budget and appropriation process is necessary to meet the challenges described in section 4. More transparency and greater sustainability can be achieved by changing the way we fund existing foundation services as well as by tying increasingly more of the appropriation to those services that are targeted on high return population segments and/or those

services that better meet future demand (i.e., where DHBs do not have sufficient incentive to provide from their existing funding).

## 8.1 Four pools, many funds

In particular, we propose the creation of four pools of funding:

1. **Existing foundation services** to maintain and develop those existing services in a district, region or nationally that are “foundation” because they not covered by the other three pools. This pool would continue to attract by far the largest portion of the health vote for some time;
2. **Government priorities** for immediate government priorities (e.g., electives and wait times) where the results are well specified. This pool is likely to remain around current levels unless government adds new priorities that do not qualify as health investments;
3. **Health investments** for investments that benefit individuals and enhance the financial sustainability of health services and where the results can be well specified and the benefits are largely produced and captured within health (e.g., long-term condition management). This pool would take a small proportion of the health vote to begin with and grow over time; and
4. **Social investments** for investments where the results can be well specified and where the benefits are largely produced and/or captured by and within the social sector (e.g., rehabilitation, improved mental health, better outcomes for vulnerable children). This pool would also take a small proportion of the health vote to start with, as well as funding from other Votes that will benefit from these investments (and governed either by a joint venture of the social sector agencies or by new organisational arrangements).

The investment approach would be applied in the two investment pools. These two pools would be made up of a number of separate funds defined by the results the fund aims to achieve for a specific population segment and geography. These funds would be targeted on those segments of the population where prevention, early intervention and rehabilitation are most likely to generate the highest fiscal and individual benefit (e.g., people on benefits who need rehabilitative services, younger people referred for mental health services, people with complex conditions). In most cases, we do not currently have the information or funding expertise to target fund management on reducing an ACC-style actuarial valuation. Instead, this Review suggests a funding model for this “information-poor” context that has 10 generic elements and illustrates how these elements can be tailored to manage different funds.

This approach provides Ministers with greater influence over where the health vote is spent because they will determine the size of each pool and what is included in each pool. Transparency is designed into the priorities and investment pools and is improved in the foundation pool (see sections 8.3 and 9 for more detail on foundation services).

The health investment pool also provides Ministers with a very transparent way of assessing what is being done to ensure longer-term sustainability of the public health system and allows them to allocate more funds specifically for this purpose, if the benefits justify that expenditure.

Moreover, as officials learn how to manage this new approach, more of the health spend will be considered in greater detail on the same timetable as the budget process for other social services (indeed, the social investment pool would be treated in this way immediately).

This approach does imply that a higher proportion of health funding will be delivered in “funds” that effectively “ring-fence” funding to deliver high-level results for well-defined population segments.

However, that does not imply that services will be more fragmented; quite the reverse. Funding this way encourages service integration because well-integrated services are required to deliver high-level results tailored more closely to individual needs. Indeed, unless entities are able to deliver a comprehensive set of well-integrated services, they are unlikely to meet the qualification hurdle and so would not be funded (see section 8.3.1). Funding individual services, or providers, fragments the patient experience of care and often requires “navigators” to compensate, while the approach we have suggested guarantees a unified service when it is necessary to deliver the desired result.

## 8.2 Transition

In terms of transitional arrangements, it is likely that existing foundation funding will gradually shrink as a portion of the total health vote as new money is increasingly focused on the investment pools. We also suggest that, at least to start with, the first three pools (foundation, immediate priorities and health investments) are managed within the DHB and Ministry planning and funding process, albeit one with different characteristics from the current approach.

## 8.3 Approving plans and budgets

In particular, the current planning and funding approach needs to be changed to create much stronger incentives on providers (including DHB provider arms and DHB-led alliances) to:

1. Put their best plan forward for approval; and then
2. Deliver a result that is either on plan or better than plan.

For example, for the foundation funding pool, DHBs who plan to deliver more and higher-quality results can be recognised by funding them some months in advance so they enjoy a cash flow advantage. This creates a financial incentive on DHBs to produce higher-quality plans rather than just doing the minimum necessary to comply with the planning guidance and secure Ministerial approval, as is the case now. The Ministry should encourage DHBs to deliver their plans by withholding some proportion of funding if plan milestones are missed.

### 8.3.1 Eligibility to submit plans

DHBs would be expected to submit plans for their share of the foundation, priority and health investment pools (and possibly funds in the social investment pool): i.e., a modified version of the current annual planning process. Other public and private (e.g., PHO, NGO) entities would be able to submit plans for funds in the investment pools, and some elements of the other pools, as they are qualified to do so.<sup>8</sup> Indeed, some PHOs would be well placed to take the lead in submitting plans to access funds in the health investment pools.

It is important that non-DHB entities are considered alongside DHBs. There is a real tension between the funding and provider functions of DHBs: DHBs are always going to have one eye on supporting their own provider arms, even when they could fund better health outcomes for their local population by supporting primary and community providers that they do not own. The Ministry already directly funds non-DHB entities to deliver services.

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<sup>8</sup> For example, private entities like PHOs, NGOs, private hospitals or residential aged care providers might collaborate in leading a plan to deliver a result funded out of the priority and health investment pools and contract with DHB provider arms for the hospital services required to provide the range of services necessary to deliver the funded result. It is possible that these private organisations might be part of more than one plan submission: e.g., as part of a DHB-led submission and as part of some other entity's submission.

To mitigate the risks associated with the transition to this new funding environment, the Ministry/NHB would qualify provider entities before they enter the funding process to ensure that they are able to bring together all of the services required to deliver the funded result to a reasonable standard and manage the financial risk associated with having payments linked to result milestones. Provider entities would also need to have the ability to collect and report data on the results that the fund has been established to promote. In short, the Ministry/NHB needs to be able to form a judgement about the capacity and capability of submitters to successfully execute the plans they put forward.

The qualification process can accommodate a variety of arrangements; from relatively straightforward arms-length funding arrangements through to more complex alliances and joint venture arrangements as described in section 2.3 above.

DHBs would qualify, although would be required to include arrangements with PHOs, NGOs or other private providers when their services are required to deliver the funded result. Districts that already have local alliances that take joint decisions about service design and delivery by engaging clinical leaders from both the DHB and PHOs, for example, would be well positioned. Those districts that do not have such well-developed alliances would either need to strengthen their alliance or would need to submit a DHB- or PHO-led plan or both. More of an outcome-based development of the emerging IPIF would be one way forward for qualifying PHO–DHB alliances. Depending on the service or fund, other entities from either inside or outside the district may also qualify.

Builders provide a useful analogy of an aggregating entity (a head contractor) that brings together a range of very different specialist sub-contractors to deliver a funded result: in this case, a house built to agreed specifications and cost. We would imagine that aggregating entities would emerge and – along with alliances, large comprehensive service providers and DHBs – would be the sorts of entities that would be qualified to submit plans.

This approach is locally tailored and recognises existing local arrangements where they are effective but provides a mechanism for challenge and change when they are not. It delivers meaningful control over services to primary care professionals and NGOs where they have the capacity to take this up, but the particular mechanism for that control varies according to local circumstances and capability. Finally, the qualification process allows judgement to be applied to the phasing of this process so that, for example, strong primary-led plans do not disenfranchise clinical leaders in secondary care, and vice versa.

### **8.3.2 Plan approval**

Higher-quality plans in the non-foundation pools would be more likely to be funded so there is a strong financial incentive to produce the best possible plan in these pools. For foundation funding, there is also an incentive to provide a good plan because the better plans would be eligible for advanced funding.

This represents a significant change in the planning and approval process for existing foundation services. When combined with the more detailed changes to foundation services funding described in section 9 below, these changes should help to generate better value for the money spent on these services and greater transparency around that value. The stronger incentive on DHB Boards and management should also reduce the extent of detailed planning guidance required from the Ministry.

Separating out the priorities and investment pools and tying funding to results in these areas make it very easy to: see what results are being produced for the money spent; identify spending priorities;

and reallocate spending into those pools and funds that generate the highest benefits. This all promotes the transparency Ministers are seeking.

### 8.3.3 Encouraging plan delivery

Dispensing funds on achievement of plan milestones means withholding some of those funds if those milestones are missed and returning that money to the same community by engaging other providers to either make up for the shortfall in specific services promised in the plan or providing other services in the same community or to the same population segment. This is another measure to mitigate any harmful effects on populations served by DHBs that do not plan and/or execute well.

DHBs will have to think carefully about the milestones they propose and DHB Boards will have to closely monitor performance against the milestones. This should, however, reduce the need for the current degree of reliance on Ministry/NHB administrative measures to create the same incentives.

### 8.3.4 Transition

Paying on milestones in the foundation pool would take a bit of getting used to. It may make sense to limit the amount of money that could be withheld and gradually increase that limit over time as DHB Boards get better at governing this approach and officials develop more options for making up any service shortfalls when milestones are missed. Once the limit is hit, the current administrative measures that reduce discretion and add compliance burden would kick in.

## 9 Funding Existing Foundation Services

Existing foundation services are largely diagnostic and treatment services available on a universal basis and, within that, the costs are typically dominated by hospital-based treatment services that are the province of DHB provider arms. That said, good service design must include the whole patient journey pre- and post-hospitalisation, so DHB plans and DHB-led provider entities will need to include both DHB-owned providers and private primary and NGO providers: i.e., provide integrated solutions that span the range of services necessary to deliver the improved health and independence that consumers need.

This pool would also include the funding devoted to improving access to primary care.

While this pool should become *relatively* less significant over time, it is likely to remain very large for the foreseeable future.

The budget process changes described in section 8 should go some way towards improving transparency and value for the money spent on existing foundation services. However, these are not sufficient to address the challenges described in section 4. This section of the Report describes what else can be done to better meet those challenges in the existing foundation services pool.

### 9.1 Improving transparency

The changes suggested in section 8.3 above require the Ministry/NHB to be clearer about the criteria it will use to assess plans at the same time as it encourages DHBs to demand greater clarity about what is required. Planning guidance is no longer a compliance exercise; real money is at stake.

#### 9.1.1 Clearer definition of results

That will encourage both the Ministry/NHB and the DHBs to look for ways of assessing the benefits generated from these foundation services and define success criteria in terms of those benefits.

For these services, consumers typically lack the degree of provider choice necessary to tie funding directly to the choices they might make, either through individual budgets or even by having funding follow the consumer (beyond inter-district flows). Funding for a more transparent and patient-centric system requires that we use a different approach.

Given the nature of the services, these results are likely to be defined in terms of survival, restorative function and consumer satisfaction (e.g., for prostate cancer treatment, the restorative benefits are likely to be defined in terms of maintaining sexual function and urinary continence following treatment). The survival and restorative standards that we should aim for are best clinically determined, with the relevant specialists being asked to define them and make consumers aware of what they can expect.

Consumers are best placed to know what they were wanting to achieve from the treatment and if the experience of care was satisfactory. Including consumer's assessments as a common result measure for foundation services will require far more effort being devoted to assessing, understanding and responding to what matters to consumers in both the design and delivery of services. It will also encourage DHBs and others to engage consumers in co-creating improvements in service design.

Most DHBs engage in some level of consumer consultation and collect some ex post satisfaction metrics. What we are proposing here is a deeper and more systematic engagement with consumers that needs to become more common-place. Some DHBs are already putting greater emphasis on using more, and more discriminating, patient surveys and focus groups and engaging in meaningful forums with consumer advocacy groups. Others are not. Judging plan quality in part on consumer assessments should encourage the latter DHBs to give their local consumers more serious attention.

There is likely to be a cascade from high-level goals, through contributory goals and indicators and so on down to activities associated with these contributory goals and indicators. This creates strategic alignment between the high-level goals that the centre is reasonably able to define and the contributory goals, indicators and activities that are better defined in dialogue with others. This strategic alignment provides the centre with some confidence that plans put to it will deliver the high-level goals Ministers want to fund.

#### **9.1.2 Better indicators of foundation system performance are needed**

It is also critical that the Ministry/NHB monitors a few key indicators of foundation system performance (including service quality), so that universal foundation services do not deteriorate as we put more emphasis on funding specific results that are easier to define (especially in the priorities and investment pools). While there is plenty of information already being collected, this has to be turned into intelligence to support well-informed judgements about the quality and sustainability of foundation system performance.

DHBs will need to be clearer about the benefits their plans aim to deliver, at least in terms of survival, restorative function and patient satisfaction, for key services in their plans because a better plan will attract advanced funding. The current government priorities with their focus on financial performance and health targets, like elective services and emergency department (ED) waiting times, also provide some useful indicators of system performance. Some DHBs may be using other system-level indicators that are worthy of wider application (e.g., Canterbury has found that the time a patient spends in the formal healthcare system correlates positively with cost and inversely with quality and so reducing that time is seen as a useful indicator of wider system performance).

Moreover, the Health Quality and Safety Commission is developing potentially useful quality indicators.

The Ministry/NHB already monitors population-level outcomes as well as DHB performance indicators. The Treasury has also developed six DHB-level indicators based on existing data sources: i.e., financial performance; hospital productivity (albeit you do not want this indicator to discourage treating people outside of hospitals); ED waiting times; mortality following acute myocardial infarction; ambulatory sensitive hospitalisations; and new mental health admissions.

There has also been considerable work undertaken over the last year or so to engage with the sector to develop an Integrated Performance Improvement Framework. One advantage of this work is that these indicators are developed and owned by providers with a heavy clinical input. This work needs to be completed, with any latent objections surfaced and addressed.

Developing the required intelligence to form a more refined judgement about the quality and sustainability of system-wide performance is not a precondition to shifting to the funding arrangements proposed in this Review. However, this needs to be strengthened at the same time as the changes we are suggesting put more focus on specific results for specific population segments in specific locations.

## 9.2 Strengthening financial and clinical sustainability by facilitating adjustment

### 9.2.1 National price calculations

National prices for foundation services are calculated by the Ministry/NHB and used as a default for pricing inter-district flows: i.e., what a DHB will pay to another when a member of its population is treated out of its district. Different DHBs also rely to a varying extent on national prices for cost benchmarking, planning and internal resource allocation.

National prices are calculated on the fully absorbed *average* cost of a hospital-delivered service using cost and volume data from about half the DHBs (and cover about 80% of the hospital services they provide). The average cost of a service can vary significantly across DHBs and the DHBs who provide the data are likely to be those at the higher cost end.<sup>9</sup> The national price is guided by this average cost but may be set above or below that average. While actual cost growth is reduced by application of an efficiency adjustment, over the last six years, average cost per case weight has increased by about 25% (i.e., faster than either consumer prices or labour costs).

### 9.2.2 National prices and PBFF adjusters slow down adjustment

To the extent that national prices drive funding and resource allocation within and between DHBs, they tend to accommodate existing service models delivered in an average way, something that slows the required adjustment in service models required to meet changing disease burdens.

National prices could encourage more service from the funding available if these prices were set:

1. Closer to what the service can be provided for by the lower-cost DHBs (to encourage high-cost providers to learn from lower-cost providers and/or to shift more demand to the lower-cost provider);
2. Closer to marginal cost during those periods when surplus capacity was available at local regional or national level (to make better use of capacity at these three levels – see next section); and

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<sup>9</sup> Our understanding is that the mix here is skewed towards the larger DHBs with tertiary functions.

3. Based on the most efficient service model (so if it were more efficient to avoid hospitalisation by providing earlier intervention in a primary or community setting, the national price would be based on the cost of the latter service model). This would help encourage uptake of lower-cost service models.

Ideally national prices would reflect the least costly way of meeting different patient needs at different times, given different levels of acuity (e.g., the cost of rehabilitation for a young and fit person is likely to be much lower than that for an older person with co-morbidities). Calculating this ideal national price is a tall order but we can move closer to it in a couple of key areas.

An important impediment to DHBs changing service models is that DHBs with slow or no population growth have surplus hospital-based capacity for significant periods of time. Their marginal cost of hospital-based services may well be significantly below their average cost (especially if the need to maintain a minimum clinical roster means clinicians are under-utilised, which adds to largely fixed facilities and corporate overhead costs – and the latter two are about a quarter of total costs).

In this case, investing in primary and community care will simply add to total cost until hospital capacity can be reduced. Reducing hospital capacity requires community and government agreement that might only be forthcoming when it is impossible to sustain a quality service or when facilities need replacing.

In the meantime, national pricing and the PBFF adjusters tend to accommodate existing costs (e.g., a rural adjuster makes it easier to hang onto surplus rural capacity; a tertiary adjuster discourages rationalisation of tertiary provision). All this slows the necessary adjustment in service models and so creates a problem for the future. This is not necessarily an issue for districts with strong population growth. If they want to, they can simply slow the growth of hospital capacity as more care is delivered closer to home.

### 9.2.3 Making better use of existing capacity would help speed adjustment

DHBs should be more willing to invest in primary and community-based care, the more confident they are that this would substitute for more expensive hospital-based care rather than simply add extra cost. They should be more confident in this substitution effect if they could make better use of the existing hospital capacity by encouraging the movement of clinicians and patients to districts with significant periods of excess physical capacity.

That would also provide patients who were willing to travel with the option of faster treatment. For most patients, faster treatment means better treatment and for some it is a major factor in their chances of the best possible recovery, so the incentive on patients to seek out faster care can be quite strong. If providers were funded for better outcomes, like restoring function in stroke victims, they would also have the financial incentive to provide faster care, especially for those cases where it mattered most.

With current IDF funding, even DHBs with relatively high capacity utilisation have a financial incentive to make patients who are not in a critical condition wait until they have capacity available to treat them locally rather than pay relatively high average IDF prices to send their patients to neighbouring DHBs with the capacity to treat people sooner and at lower cost to the system.

One approach to better matching demand with capacity is to use a clearing house at regional and/or national levels. DHBs would be required to use one set of criteria for assessing patient eligibility for the service, and waiting lists would need to be managed regionally and/or nationally by a clinical governance group that is independent of any one of the DHBs.

Under a regional model:

1. DHBs in the region submit an annual plan to the regional clinical governance group (RGG) for the service that set a budget for referrals (for both First Specialist Assessment (FSA) and treatment) that they expect to accept, operating costs for those acceptances and their waiting lists at the beginning and end of the year;
2. Each day DHBs submit the numbers accepted for FSA/treatment as well as those actually assessed/treated respectively to the RGG, which manages the regional waiting list;
3. The RGG reviews the list weekly, identifies patients that need to be assessed/treated during the next month and checks whether they have been booked for assessment or treatment; if the patient has not been booked, the RGG contacts them to see if they would be happy to be assessed/treated at another DHB in the region and, if the patient is happy with this option, the RGG will liaise with the referring and treating DHB hospitals;
4. The RGG produces monthly reports showing which patients have been assessed/treated by which DHB and the district waiting list by wait time, and it receives from DHBs the direct and indirect costs of assessment and treatment for the month; and
5. Annually the RGG compares actual volumes and costs by DHB, the number of patients that had to wait longer than the agreed maximum period and service quality outcome measures (e.g., survival, restorative function and consumer satisfaction). To the extent that actual operating costs were under/over budget, this benefit/cost would be shared between DHBs in the region based on principles agreed beforehand.

Under a national model, each DHB would submit to a national clinical governance group (NGG) each month: its waiting list; the additions and subtractions it expects to make on that list over the coming month; the extra assessment capacity it had over that month; and the price at which it would take patients for assessment/treatment from other DHBs during that month. The NGG would contact patients that are having to wait longer than desirable to see if they would be willing to travel to be assessed/treated at another DHB and, if so, would match those patients with those DHBs that had the capacity to assess or treat sooner. If the quoted price was lower than the national price, it would be possible to offer a travel subsidy up to the national price. The origin DHB would pay the destination DHB the quoted price and the patient any travel subsidy: i.e., the origin DHB would pay no more than the national price.

The national model is a little simpler and more likely to result in patients travelling because DHBs would have an incentive to reveal their marginal costs and some of the benefit of that would be passed to patients via the travel subsidy. On the other hand, the national model is also likely to produce more variability in individual DHB revenues than the regional model. It may be sensible to use a national model for services where inter-regional flows are more prevalent and a regional model where almost all of the patient flows are between DHBs in an existing region. While either model is likely to require more refinement, our main point is that a clearing house approach is likely to produce a better use of existing hospital capacity and, therefore, earlier assessment and treatment for patients as well as a stronger incentive for DHBs to look at primary and community-based alternatives.

While these are useful measures, they can only be seen as transitional: i.e., helping to address the problems caused by significant periods of hospital over-capacity until that capacity can be either permanently employed or reduced. Obviously, it would be better to address over-capacity issues

early and directly. However, this has proved almost impossible without local community support and that has proved very difficult to secure (so may only happen when facilities need replacing or specific services become clinically unsustainable in some districts).

#### **9.2.4 Changing employment arrangements would also help**

Specialist clinicians who are employees of one DHB are reluctant to work in other DHBs and some are discouraged by barriers to working in other DHBs, especially concerns over their liability and authority in dealing with other DHBs' patients. Incredibly, it has been easier for one DHB to arrange mutual specialist tele-support from an Edinburgh hospital than to arrange similar cover from the neighbouring DHB (i.e., advice from an on-call neurologist to help less specialised hospital clinicians deal quickly with stroke victims). One answer is to make specialist clinicians who feel discouraged from working elsewhere into employees of all of the DHBs in a region (or an existing collective regional DHB-owned entity), as well as making all new specialist clinical staff employees of the region.

#### **9.2.5 Responding to these new incentives with new service models**

These changes in national prices, management of IDFs and employment arrangements would create an incentive on DHBs to identify and adopt models of care that could meet the likely increase in demand for various services for a sustainable increase in spending.

Luckily, the required service model changes have already been identified for a number of services. Health Workforce New Zealand (HWNZ) has been engaging clinicians to identify the changes in existing models of care that would be required to meet a doubling of demand for their services with a 40% increase in their funding. While HWNZ has been primarily concerned with using this work to help identify changes in workforce composition that would support these new models of care, the same process could be used to identify the way service design will need to change to keep up with increases in demand for foundation treatment services in the face of limited extra funding. Indeed, the HWNZ work would be a useful starting point for a more comprehensive service redesign programme (see section 14.4). The changes proposed above would give DHBs more ability and incentive to adopt these new service models.

### **9.3 Improving equity in foundation services**

#### **9.3.1 Improving access has been a matter of subsidising the cost**

Funding to improve access has traditionally focused on subsidising the cost of access to healthcare to the point where all hospital care is free to the user, and user co-payments to primary care are limited.

Co-payments for access to general practice are controlled as part of the national PHO Agreement whereby individual practices agree to limit their fees per consultation and meet some other conditions, like after-hours access, in exchange for a capitation payment. The Agreement is negotiated at the national level and terms apply nationally. Similarly, co-payments for pharmaceuticals can be limited to \$5 per item up to a maximum of 20 items per annum. DHBs pay for drugs (sourced via Pharmac) and their dispensing and distribution by pharmacies (with costs for the latter managed through a national Pharmacy Agreement that sets a margin paid to individual pharmacies to cover wholesaling costs, a dispensing fee and a capitation payment for high needs patients they enrol).

Encouraging patient access to primary care has benefits to both patients and the Crown from, for example, early detection and treatment and from keeping less serious cases away from hospital emergency departments (EDs) and more expensive residential care.

### 9.3.2 Current arrangements are not well targeted

The government will secure the greatest return when its subsidy is targeted on: the greatest barriers to patient access; the people who will be most responsive to those barriers being reduced; and those cases where the wider public benefit of better individual access to primary care is highest.

Current arrangements do not stack up well against these criteria.

#### *a. Faster access*

Ensuring appropriate access on a timely basis to primary care is a cornerstone of a good health service. While cost is still an issue for some, the ability to schedule an appointment at a person's usual medical centre within 24 hours is now cited as a more common barrier to access (especially so for children).<sup>10</sup> Clearly, concern about securing this sort of appointment is a concern around non-urgent care. The current PHO Agreement only requires that PHOs must provide access to services by the general practice team (or another provider agreed by the Ministry) with no requirement that consultations be provided within any particular time-frame.

#### *b. Better targeting to income and need*

More significantly, surprisingly little of the current subsidy is targeted on people with low incomes or who have high health need: i.e., those for whom cost is likely to be the biggest barrier to access. Capitation has been largely used to cap co-payments for everyone, regardless of individual circumstances.

There are additional payments made to general practice to try to encourage practices to further reduce co-payments to people on low incomes or those with high health need (e.g., Very Low Cost Access (VLCA); High User Health Card (HUHC); Community Services Card). However, even these are not well targeted and, because they are seen as trade-offs for lower patient co-payments, are paid to general practice with no obvious accountability for changing the service provided. The pharmacy co-payment has a stop-loss at 20 items per annum (equivalent to \$100 per annum cost), which does not vary by income.

For example, VLCA was initially paid to those practices that signed up and agreed to further reduce co-payments to their entire enrolled population. Extensions to VLCA was subsequently restricted to those practices that had more than half their patients in a low income group. The net result is that a little over half a million people defined as high needs are not enrolled with VLCA practices and so miss out on the higher levels of government subsidy while about the same number who are not defined as high needs are enrolled with VLCA practices and receive the higher subsidy.<sup>11</sup>

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<sup>10</sup> NZ Health Survey: unmet need for primary healthcare. This may be because the introduction of capitation seems to have at least coincided with a reduction in general practitioner hours worked and the availability of after-hours service (see Medical Council of New Zealand data on hours worked).

<sup>11</sup> A discussion paper by Tom Love and Gary Blick for General Practice New Zealand in 2014 found that only 56% of the high needs population was with a VLCA practice and the rest were enrolled in a non-VLCA practice. Moreover, of the nearly 1.3m people enrolled in VLCA practices, 44% were not defined as high needs.

*c. Increased focus on results*

In practice, most of the funding to primary care is focused on reducing the cost of people accessing the service, including extra payments to reduce costs for individuals with high needs for primary care.

In recent years, however, there has been some extra funding, especially Care Plus, aimed at encouraging general practice to do more when early intervention is likely to reduce subsequent health costs (e.g., helping people manage their long-term conditions better at home). However, these payments are typically not conditional on results. While Care Plus pays a higher capitation for these more time consuming cases, the payment is justified by extra cost to the practice, rather than being conditional on better outcomes for the patient or even lower downstream costs to hospital and residential care.

Similarly, while the National Pharmacy Agreement has changed recently to substantially reduce the subsidy paid per item dispensed in favour of a monthly capitation payment for patients that are assessed as high needs, none of these payments is made conditional on better results for patients.

### 9.3.3 Proposed changes to the foundation capitation payments to improve access

Improving access for those on low incomes or with high health need should be seen as part of the existing foundation funding pool. With this capitation funding, immediate gains could be made by reducing the foundation capitation payment and using the resulting savings to:

1. Alter the PHO Agreement to require recipients of capitation to ensure that any patient requiring non-urgent attention can schedule an appointment with an appropriate primary healthcare professional at their usual medical centre within 24 hours, and to require PHOs to be able to track the wait time from the date of contacting the practice for an appointment to the date of being seen; and
2. Increase the subsidy – and reduce the co-payment – for those on low incomes and to introduce a stop loss for those who would currently qualify for Care Plus: i.e., a maximum amount that those on different incomes would need to pay in a year for general practice visits and pharmaceuticals. This subsidy would be attached to the enrolled patient rather than being paid to the practice with consultations only being “usually provided at lower cost” to the patient. Ideally, low income would be identified using Ministry of Social Development and/or Inland Revenue data and an individual’s subsidy status attached to their National Health Index number so that their eligibility was automatic (i.e., not dependent on their application). The desire to change service models through Care Plus is best addressed through the investment funds, leaving the above changes focused on improving access.

It makes sense to continue to fund capitation through the PHO because it is the PHO’s responsibility to ensure that practices are complying with the other elements of the National Agreement (e.g., on providing after-hours care). However, the Ministry would need to ensure that these funds were simply passed through to practices as capitation payments in those cases where practices were compliant with the Agreement. PHOs receive a management fee so should not have to top-slice practice capitation payments for this purpose.

For those consumers who are better off and who do not have high health need, general practice would have to increase their fees to compensate for the reduction in capitation subsidy and the Agreement amended to allow this to happen.

The implications of reducing the non-targeted proportion of the capitation payment do not appear to be particularly constraining. While it might encourage some higher-income people to go straight to ED, they may well prefer to pay a little more for a shorter wait time at the general practice clinic, rather than face a much longer wait time for a free consultation at ED.<sup>12</sup> Very few practices have a high enough proportion of high-income patients for it to be worth their while withdrawing altogether from capitation so that they can charge what they like. Finally, the risk that reducing the degree of universality will seriously undermine public support for the subsidy seems rather remote.

*a. Better informed patient choice*

Finally, consumers find it hard to make an informed choice in selecting a practice because there is no requirement to publish information on elements of practice performance that would be of interest to consumers. This undermines one of the stronger arguments for capitation: i.e., that more funding should end up in the hands of practices that are most attractive to consumers. More targeted funding arrangements should be supported by requiring publication of information on the quality, availability and timeliness of care at individual practices. That would also help to make primary care more patient-centric.

*b. Transitional arrangements*

Some transitional arrangements will be required to give practices time to adjust their business and operating models to these new funding arrangements. We would suggest moving all practices to the new arrangements at the beginning of the fiscal year 2016 but spread any negative revenue impacts on individual practices over the following two years; e.g., making up for, say, all of the loss in 2016, half of the loss in 2017 and then nothing from then onwards. This does not prolong the transition and makes it very clear that the new arrangements are here to stay, while giving those providers who lose out time to adjust.

#### **9.3.4 Increasing the focus of primary care on results**

We need to be clearer about when we are subsidising consumer access to primary care and when we are trying to change the behaviour of general practice and pharmacies to encourage more and more intensive focus on those population segments where this will deliver better results: i.e., when funding is aimed at changing the behaviour of consumers and when it is aimed at changing the behaviour of providers. Conflating the two motivations may give the impression of getting more for the money but it actually dilutes the effectiveness of both funding streams.

The non-financial motivations of general practitioners and pharmacists are typically focused on delivering better patient outcomes and this will be a major driver of better outcomes. Moreover, the IPIF process suggests that there are a number of non-financial incentives, like better access to secondary services, that are well aligned with clinicians' non-financial motivations and so have a powerful influence on behaviour. Financial incentives must work in the same way and not try to substitute the judgement of funders for those of professional clinicians when it comes to how best to care for a patient.

One thing that funders can do is reflect back to primary care at least some of the financial benefits that are associated with better primary care; like increased patient employability, reduced patient

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<sup>12</sup> Our review of the ED presentations in an Australian state shows that more than half of the presentations were completely inappropriate; i.e., they should have been managed in a community setting. A co-payment or a required payment from the primary care group with which the person is enrolled would be two funding mechanisms to encourage increased community capacity and to discourage otherwise unnecessary expensive hospital presentations.

welfare dependence and reduced demand for expensive hospital or residential care. Additional funding that is not targeted at improving access should be conditional on delivering results of this kind; results that are also typically consistent with their patients living healthier and more independent lives. This is far better than tying payments to how a funder thinks clinicians should be delivering care; e.g., to conducting certain tests or preparing care plans.

Funding should also encourage teamwork across traditional professional boundaries, which is often so important to delivering a better result for patients. It should encourage, for example, much closer collaboration between pharmacists and general practice and between primary and secondary care clinicians. Such collaboration is discouraged by separate funding streams that support very different business models, even between general practice and pharmacy, let alone between primary/community and secondary providers.

All of that suggests that “investment-style” funding aimed at changing primary care provider behaviour to reduce future costs elsewhere in the system, like Care Plus, is best delivered via the health investment pool and targeted at delivering well-defined results for well-defined population segments.

The rationale for creating this pool is to increase investment in these areas to better meet the challenge of increasing chronic demand by managing this demand closer to home. Plans are only likely to be funded if they can deliver effective primary and community services and, indeed, may actually be led by primary and community care organisations that contract for the secondary services required to deliver a comprehensive service.

Funding successful entities on the basis of the results they achieve, rather than the costs they incur to deliver a service, should produce much better incentives both to increase the benefits derived and to reduce the cost to serve. Because providers can use savings to deliver better outcomes and so improve their revenues, they would, for example, have every incentive to reduce harmful variation in prescriptions, diagnostic tests and referrals – all of which are significant sources of waste and harm. Paying for results does, therefore, automatically capture the cost-saving benefits of budget holding without creating concerns that costs will be saved at the expense of better results.

This approach would also overcome the perverse incentives created by reliance on a combination of fee-for-service and capitation. Fees paid per consultation create an incentive to provide more consultations (e.g., through less time per consultation). Capitation creates an incentive to enrol lots of patients (especially less costly patients), reduce the cost to serve (e.g., by providing less after hours) and increase activity in non-regulated areas (e.g., cosmetic consultations). It may be that keeping a rough balance between these two forces modifies the worst elements of both, although we have not seen any evidence to support this. However, it does not address the fundamental weakness in both funding mechanisms: neither focuses attention on producing better outcomes for the money spent.

## 10 Funding Government Priorities

### 10.1 Why have a separate priorities pool?

While all governments will be concerned to improve the overall health system, different governments will also have different health priorities and want to ensure their priorities are adequately funded. The advantage of having a separate pool for funding these priorities is that it meets this need without automatically destabilising the other funding pools. While governments can always take funding out of

one of the other three pools to fund their priorities, that would require an explicit decision, with transparent consequences. Our recent experience also suggests that tying some funding to the delivery of these priorities is more likely to result in delivering on these priorities.

## 10.2 Lessons from experience with funding government priorities

For some time now, governments have expressed their health priorities in terms of health targets, which sit alongside their financial priorities (usually expressed in terms of DHBs controlling, reducing or eliminating DHB deficits).

The new government in 2008 reduced the number of health targets from ten to six. It retained five from the 2007 list (immunisation, elective surgery, cancer waiting times, smoking and diabetes services), although some had different performance indicators, and the diabetes target was expanded to cover cardiovascular services. A new target for shorter stays in emergency departments was added. The five 2007 targets that were dropped related to oral health, ambulatory sensitive hospitalisation, mental health, nutrition/physical activity/obesity, and the Ministry of Health's proportion of health spending. Given the more direct influence Ministers have over the last area, it always seemed quite different in kind to the other targets.

We can draw a number of lessons from the experience over the last decade:

- Simply holding DHBs to account and expecting them to reflect government priorities in the way they spend their PBFF allocation is not successful (which illustrates the limited reliance that can be placed on simply “allocating” funding combined with central “monitoring”).
- Explicitly tying additional funding to the successful delivery of results in the target area has been very effective.
- Publication of DHB performance against targets seems to provide a useful spur to better DHB performance.
- Targets like more elective surgery and reduced wait times can help improve system performance because they are hard to meet without also doing a better job across the system (e.g., in reducing ambulatory sensitive hospitalisation and length of stay).
- You can at least encourage some consideration of better use of regional capacity by making payments to any single DHB in a region conditional on the whole region meeting its target.

The experience with elective surgery highlights the degree of success that can be achieved, at least when it is reasonably easy to define the desired result and fund on what is close to a fee-for-service basis. Prior to 2008, elective surgery discharges fell behind what would be expected from population growth despite relatively large increases in PBFF funding. Since 2008, DHBs have tended to exceed the target, despite smaller increases in PBFF funding and a relatively modest top-up tied to elective performance (e.g., an average of around \$10m a year cumulatively since 2008).

## 10.3 Managing priorities when different pools influence the same target

This top-up elective funding also illustrates how it is possible to operate two funding pools simultaneously to reinforce their impact in delivering a target result. DHBs have to produce about half the targeted amount of elective surgery out of their PBFF funding before being eligible for funding from the elective pool. In this way, the PBFF and elective pools in the existing system are integrated. While adding two more funding pools will require some thought, the elective experience demonstrates that different funding pools can work perfectly well together.

## 10.4 Transition

The current government has a set of established health targets and has made good progress towards those targets. As funds are developed for the health and social investment pools, some are bound to contribute to existing targets and this will need to be taken into account in the way the funds are managed (e.g., enabling more older people to stay in their homes for longer is likely to require increased funding for cataract surgery, which will contribute to elective volumes).

# 11 Designing the Health and Social Investment Funds

We propose that the plan approval process discussed above be the basis for designing a funding process for the two investment pools. This process can be used to create much sharper provider focus on producing and delivering results. Moreover, at least initially, health investment funds would, along with foundation and priority funds, be managed within the DHB and Ministry planning and funding process.

## 11.1 Overall design considerations

There are a number of common elements that need to be considered in designing a funding process for the two investment pools; e.g., identifying the target population segments and locations, defining the desired results, valuing the results, and provider qualification. These generic elements of the funding process need to be tailored to the circumstances of each fund.

## 11.2 Existing information and expertise limit initial design choices

The key limiting factor that needs to be considered in shaping fund design is the information and expertise available to manage the funding process.

While the way ACC manages its accounts and funding process has much to recommend it, it does have a heavy information and expertise requirement that ACC has taken time to develop: e.g., being able to calculate the actuarial cost of the existing injuries being funded out of each account (ACC's "account" being equivalent to a "fund" as we use the term here).

While we would want to move towards that sort of approach where we can, there is only one potential fund that we can see as an immediate candidate for consideration: treatment injury. For most of the likely health and social funds, we are starting off in a relatively information-poor position. That determines how we design the funding process, at least initially.

## 11.3 Transition: Common approach

For both investment pools, transition is best thought of in terms of portfolio design: what is the right mix of funds in each pool initially and what is the process for assessing and approving both additional funds, and including additional population segments and locations in existing funds, over time? The two key questions that drive this choice are: which population segments/locations are the right ones to target first and what sort of results should be defined for those segments?

Given that we are typically starting in a relatively information-poor position, we suggest that funds are chosen for population segments, locations and results where the likely benefits are large enough to justify a reasonable level of investment without worrying too much that the ultimate return will disappoint.

The initial portfolios also need to be designed with an eye to both improving the information available to make better decisions, and developing funding expertise. We have identified treatment injury and rehabilitation in part because each helps meet this requirement in its respective pool. In the former case, an ACC fund exists and just requires some modification. In the case of rehabilitation, because improving the available information and funding expertise could create an opportunity to improve the way that the sick and disabled are treated compared with the injured and to achieve a good return on the additional investment required to make that improvement.

#### 11.4 A “generic” funding process when information is poor

This section describes the generic funding process that would be adapted to suit the characteristics of each fund in an information-poor context in both the health and social investment pools.

The problem here is to: identify the right population segments/locations and define results that are good proxies for future actuarial liability; design a process that will encourage providers to put their best plans forward and then deliver to plan or exceed plan; and ensure that process also provides Ministers with the information to make good decisions about the right size of the fund (i.e., the additional money they should invest to achieve better than current outcomes).

##### 11.4.1 The generic funding process has 10 key elements

1. *Identification of the target population segment(s), definition and valuation of results:* This is the generic element that will always require customisation for each fund (indeed, these define the fund).

Funds need to provide a good return on investment as well as to produce better outcomes for the individuals involved. In terms of the former, results need to be defined that are good proxies for the actuarial liability associated with the target population (e.g., people with long-term conditions) in the target location and, if there is a lot of variation within that population, for target segments (e.g., those people suffering with one, two or three long-term conditions simultaneously).

The value of the results needs to be defined in terms of the counterfactual: i.e., what would have happened without the additional investment? When the fund has limited geographical coverage, it may be best to benchmark against other locations or a “public sector comparator” (as used in the social bond programme). In other cases, the best comparator may simply be an improvement in the current position (which is the result that is already being funded) plus something to reflect “best practice”.

While the investment has to be justified in terms of future fiscal savings, it would only be approved if it also improved outcomes for the population segment in question: i.e., both are critical. For contract renewal, the counterfactual would need to be independent of actual performance (e.g., some weighted measure, like an average, of the results achieved or suggested by all successful providers in their plans).

Target population segments also need to be defined geographically. For health investments, DHBs will focus on their district or an area of high need within their district, although it should be possible for others to submit plans for multiples of these geographic units (e.g., for more than one DHB district). The risk of displacement is reduced if results are measured as an improvement in the current position (so investment funding cannot simply displace existing funding). For the social investment pools, smaller geographical units might well be appropriate.

2. *Financing:* This will be a combination of additional government funding plus reduced funding to any existing funders or providers who no longer have to provide services to a population segment

serviced by a new provider. DHBs would still be discharging their obligation to their population by having the target population segment funded in this way (as they do now with any other service funded by the Ministry/NHB but provided to population segments in their region: e.g., disability).

3. *Provider qualification:* Provider entities are qualified by the Ministry/NHB and asked to submit a plan for managing a population to deliver the expected results. The qualification process ensures that these entities have arrangements in place that allow them to provide the necessary range of services, manage financial risk and provide information that allows the Ministry/NHB to assess performance against the desired results: i.e., qualified on the basis of comprehensiveness, risk and information criteria.

We would suggest using a two-stage qualification process: an initial screening that quickly discounted those who were unlikely to meet the criteria in the current round followed by a more in-depth appraisal of those who pass this initial screen. The Ministry/NHB may well draw on external expertise to help in these assessments.

4. *Funding term:* The time period for funding has to be long enough to give providers enough confidence in their future revenue streams to make the necessary investments in provider development without government having to allocate extra funds for this purpose (e.g., a rolling term that would not be pushed forward if performance was poor). If necessary to encourage this investment, it might well be better to put a guaranteed floor under the revenue stream for the funding period (at least on a per capita basis) than to continue funding provider development as we do now.
5. *Results valuation:* Provider entities would be informed about how different elements of the results will be valued in assessing their plans (e.g., reduced future health costs, reduced welfare dependence, and reduced convictions). Some of this work on valuing these elements has already been done as input into the social bonds programme.
6. *Plan assessment and ranking:* Provider plans would be assessed by the Ministry/NHB and ranked on the basis of the size of the likely value-weighted benefit “promised” in the plans, from biggest gain to smallest gain on a per-person-served basis (i.e., the planned benefits delivered for each population segment divided by the number of people the plan seeks to cover in each segment).

We suggest that the Ministry/NHB uses external assessors as part of this assessment process to add an independent and expert element to help inform the overall judgements being made (similar to the process used in the social bond programme).

7. *Fund size:* Ministers would then decide the quantum of investment they would make in the fund based on the returns they would expect from this fund versus other priorities. This return would be calculated as the cumulative sum of the benefits promised in providers’ plans at different value cut-off points: i.e., we would expect a lower return for each dollar invested as we increase the number of acceptable plans, so at some point this return falls below the return that could be delivered from other funds and that becomes the cut-off point that determines the size of the fund.
8. *Fund allocation:* Funds would then be allocated to the plan that promised the highest per-person-served return, the next best plan and so on until the fund was exhausted.
9. *Incentivising plan delivery:* Funding would either be clawed back if planned results were not achieved or paid out on plan milestones being delivered, with the money returned to the fund (e.g., where possible, for distribution to other provider entities to make up for this under-performance and so deliver the overall result expected from the fund). If a rolling contract term

were employed, under-plan performance would be associated with a pause in this roll (so the contract term would shorten).

10. *Encouraging out-performance*: Provider entities would be required to publish their results so that this information is available to consumers and referrers. In districts where there is a choice of provider, it is likely that consumers and referrers would favour the provider who achieved the best results. In that case, the funding would follow the choice that the consumer or referrer made (i.e., funding follows the consumer on the planned benefit per-person-served basis). This means that provider entities would make more/less revenue than planned if they attracted/lost more consumers than planned.

In some areas of health, the Needs Assessment and Service Coordination services (NASCs) have a role in assessing individuals' needs and helping individuals identify service providers who can meet those needs. In some of the new social sector initiatives, there is a "gateway review" of individual cases by representatives of the sponsoring agencies (e.g., welfare, health, education) that plays a similar role. When this sort of initial assessment is required, subsequent referral would be better informed if provider results were readily available.

In districts without alternative providers, better performance in the current period makes it easier to succeed in subsequent contracting rounds where results are calculated on the basis of performance against a regional or national benchmark. It may also be reasonable to reward out-performance directly: i.e., by paying a bonus to providers who out-perform planned results.

#### 11.4.2 This generic process addresses the problems of an information-poor context

Providers are encouraged to put their best plans forward because the better the plan, the higher the probability of funding. They are also encouraged to not only deliver the plan to secure on-going payment and maintain a decent contract term, but to exceed plan and so attract more revenue (when consumers and referrers have local choice) and better position themselves for a bonus payment or for contract renewal (when choice is lacking).

The process itself also generates the information Ministers need to prioritise their investment decisions across the health and wider social sectors. This approach would give Ministers plenty of visibility on what they were getting for the extra funding as well as greater assurance that future cost pressures were being better managed.

## 12 Funding the Health Investment Pool to Reduce Future Health Costs

Section 4.2 rehearsed the arguments for having a separate health investment pool, rather than relying on the current funding arrangements, to ensure that DHBs are investing enough in changing service models to contain future cost growth driven by changing disease burdens. The Ministry's *Briefing for the Incoming Minister* reiterated long-standing advice that achieving this objective requires relatively less investment and resource devoted to hospital care and relatively more devoted to prevention, long-term condition management, avoiding unnecessary hospital admissions, rehabilitation and end of life care (*BIM*, p. 11). While rehabilitation meets the criteria for inclusion as a separate fund in the social investment pool, the benefits from these other areas are largely produced and captured within health and so belong here.

### 12.1 Transition

The Ministry/NHB will need to identify the population segments/location where investment is most likely to yield the greatest benefits (investment in, for example, prevention and early detection, and

supporting greater self-management of long-term conditions). The population of people with long-term conditions is likely to qualify for serious consideration on this return-on-investment criterion. We would also suggest adding treatment injury as a fund because it will develop insights and expertise in managing a fund in an information-rich and funding-expertise-rich context.

Sections 12.2 (long-term conditions) and 12.3 (treatment injury) below illustrate two different approaches to fund management, sizing and financing based on the degree of information and fund management expertise available.

## 12.2 Illustration: Long-term conditions (LTCs)

This is a good example of an information-poor area where application of the generic funding model described in section 11.4 is appropriate (e.g., because little is known about the likely actuarial cost of these conditions). However, while we do not know the likely future costs associated with the growth in chronic conditions like diabetes, the consensus is that they are likely to be large. While all DHBs are typically doing something to try to manage this future cost, we have good reasons to believe that their financial incentives to invest out of their PBFF funding are inadequate, especially for those DHBs with little or no population growth (see sections 4.1 and 4.2 above).

### 12.2.1 Results

Until we have better estimates of the future liability generated by long-term conditions, we will need to define results in terms of outcomes for patients that drive that liability. So, for example, for diabetics the aim is to keep them in work, independent, out of hospital and in good renal function. The onset of renal failure is an inflection point where costs rise dramatically and the quality of life declines dramatically, so would have more weight in the calculation of overall benefits for the diabetic population. Similar indicators would need to be worked out for other long-term conditions.

Eligible providers would be asked for plans that covered four population segments with different cost and return profiles: those at high risk of developing an LTC (in cases where established risk calculations had strong predictive power), those with one LTC, those with two LTCs and those with three or more LTCs.

Like the “generic” approach, results would be defined as an improvement on the counterfactual (e.g., in current district outcomes already funded by PBFF plus something for “best practice”). A district or sub-district based approach also recognises that the PBFF allows faster-growing DHBs more scope and incentive to invest more of their existing funding into these activities: in part because population funding tends to grow faster than the growth in capacity required to service that population growth and in part because the marginal cost of hospital provision is higher for longer periods in faster-growing DHBs.

“Improvements in current district performance” can be defined in terms of improvements relative to the population (e.g., reduction in the percentage of the population admitted to hospital who have a diabetic condition) or relative to the target population segment (e.g., reduction in the percentage of those with diabetes admitted to hospital). The former incentivises both prevention and treatment of the condition in the community.

The “current district performance” counterfactual should also be reset at regular intervals, although based on an average improvement across all providers or a broader geography so that better than average performance in the initial period would make it easier to better next period’s benchmark, and vice versa. When there is only one provider in a district, a regional or national benchmark can be used.

Existing well-functioning alliances between DHBs, PHOs and NGOs would be well placed to qualify to submit plans for health investment funds but they may not be the only ones. Indeed, given that the aim is to manage people with LTCs in the community, PHO-led groupings may well qualify too, provided they could at least contract with secondary providers to deliver a comprehensive service.

In other respects, the funding process would be the same as outlined in the “generic” approach described in section 11.4 above.

### 12.3 Illustration: Reducing treatment injury

Treatment injury is injury that has occurred during treatment and that is not caused by the person’s underlying health condition or as an ordinary consequence of treatment.

Treatment injury is an example of an information-rich and funding-expertise-rich context. ACC knows the actuarial cost of those who have suffered treatment injury and has an estimate of the likely growth in that cost under current arrangements. Moreover, a fund already exists and claims against that fund are being processed by ACC. The fund is being financed out of taxation and levies to the tune of about \$234m per annum, with an actuarial liability from existing claims of about \$4bn. ACC notes that the growth in this liability is high and, if it continues, “...the lifetime costs of new claims will surpass the Motor Vehicle Account by 2020 and the Work Account by 2023” (ACC *Financial Condition Report* 2014, p. 4).

The issue here is not about which route government takes to fund this liability, or even the management of the existing liability; rather it is the likely return to government of investing in improving treatment quality and safety to reduce treatment injury and so the growth in actuarial liability. If ACC’s actuaries are correct, the potential benefits could be significant.

The way treatment injury is currently funded means that there is no financial incentive on the relevant providers to reduce treatment injury. Because ACC has the actuarial expertise, it makes sense for ACC to continue to manage the fund but for it to levy providers (including DHB-owned providers) in order to meet the actuarial liability created by the treatment injury they create.

The government could commit to reimbursing providers on the basis of what would have been paid out of general taxation on current forecasts minus a productivity dividend (i.e., a proportion of the expected savings from more active prevention strategies). This counterfactual funding path could be periodically reset. Providers would have an incentive to deliver a lower future liability from treatment injury because that would reduce their levy payments below what the government was paying in reimbursement. The difference would accrue to those providers. It would be important to DHBs and private providers that the measures they took to reduce treatment injury did not lead to an increase in the practice of defensive medicine.

## 13 Funding Social Investments

The social investment pool is used to fund future benefits that are largely produced and/or captured by and within the broader social sector.

### 13.1 Overall approach

We suggest that this pool be separately funded from the beginning and considered in the normal budget process for allocating additional funding for priority expenditure (rather than earlier in the budget process, as happens with DHBs in order to trigger their planning process).

The whole idea behind the investment funds is to invest some public money earlier to save more public money later and improve people's lives at the same time. While some of this investment will inevitably be funded from within existing social sector baselines (e.g., via top slicing), it is likely that the initial funds will be targeted on delivering better results in those areas and for those population segments where future benefits are likely to be largest. This suggests that additional public money will also need to be invested in these funds.

There are likely to be a reasonable number of early candidates for social investment funding. Below we illustrate how this pool might work with a couple of "health-heavy" fund examples: rehabilitation and mental health. However, improving outcomes for vulnerable children and at risk youth are obvious cases where early investment is also likely to yield significant benefits for the person themselves, and in terms of reduced public spending, over the person's lifetime (see, for example, the report from the Prime Minister's science advisor: *Improving the Transition: reducing social and psychological morbidity during adolescence*). Indeed, there are some segments of these sub-populations, like children in care and youth in custody, where the potential payoff is likely to be very high indeed.

There is also likely to be a wider range of private and public providers that would be eligible to submit funding plans than there are in the other three pools, although health providers would be well placed in the rehabilitation and mental health areas discussed below.

While the other three pools would be governed by the Ministry/NHB, different governance arrangements will be required for the social investment pool. One option would be a joint venture of the contributing social sector agencies, albeit with a single point of accountability for delivering results. Another option would be for existing Votes to be top sliced and the funds placed with a new agency (similar to an organisation like the "Office of Social Services" suggested in the Productivity Commission's draft paper).

## 13.2 Transition

Ministers would need advice on how best to manage the social investments as a portfolio: i.e., the right number, type and size of funds to be included in the portfolio with the highest value population segments, locations and results identified. They also need a process for assessment of new funds and their inclusion in the portfolio (including on the basis of expected return on investment).

## 13.3 Illustration: Rehabilitation

Most health systems provide a mix of prevention, diagnosis, treatment and rehabilitation. New Zealand is distinctive in that the ACC manages a social insurance scheme for injury alongside a tax-funded public system for illness and disability.

The very different incentives created by the two funding streams create contrasting results:

- Because ACC must pay earnings-related compensation to the injured, it has a very strong focus on rehabilitation that restores the injured to work-ready status as soon as possible. ACC is very focused on the work-ready result and its operating model involves active case management of the harder cases to achieve this outcome.
- On the other hand, DHBs and other health providers bear no responsibility for the welfare obligation that is created when sickness or disability leads to loss of work and so do not have an equivalent financial incentive to try to limit that cost, despite the fact that it is a real cost to the public as well as the individual concerned. The approach to both the funding of rehabilitation

and the provision of rehabilitative services in health varies considerably depending on the funding entity: i.e., Ministry versus DHBs and amongst DHBs (where there are some examples of good rehabilitative service provision, like CREST in Canterbury and START in the Waikato). There is a large recurrent cost of people on sickness and disability pensions (e.g., the actuarial liability for just those with an unmet mental health need alone is about \$4bn according to papers prepared for the Welfare Working Group).

Anecdotal evidence suggests that these different incentives lead to better outcomes for people managed by ACC for similar conditions (e.g., a number of providers have been quite clear that outcomes for under-65-year-old stroke victims funded by the health system are not as good as equivalent brain injured patients funded by ACC: see also the HWNZ rehabilitation forecast review).

### 13.3.1 Defining the population segment(s) and desired results

A rehabilitation fund would fund services to people in receipt of sickness and disability pensions with the ultimate aim of reducing the actuarial liability associated with their illness or disability. Until that liability can be established, we would need to define results in terms of outcomes for those in receipt of these benefits that drive this liability: i.e., employment, increased independence and reduced public health costs.

We could define two counterfactuals to measure value added: current district results and the results obtained by ACC for similar cases. The latter would be useful in determining the degree of ambition and feasibility built into providers' plans.

### 13.3.2 Two broad approaches to managing rehabilitation funding

There are two broad approaches that could be taken to improving funding for rehabilitation outcomes.

#### *a. ACC-style approach: A longer-term option*

In the longer term, it might be quite attractive to have an ACC-managed fund where the service providers are levied on the basis of fully funding the actuarial liability associated with the population segment that they are managing and reimbursed on the basis of the on-going cost of the welfare payments and health cost that are likely to be incurred by that population segment under current arrangements (similar to the proposed solution for treatment injury in section 12.3 above). While this is an information- and expertise-heavy solution that would take some time to develop and implement, it could be a desirable solution if it were ultimately able to improve rehabilitation services for the sick and disabled closer to those received by the injured with similar difficulties.

#### *b. Applying the "generic" approach in the shorter term*

In the shorter term, we would need to use the "generic" approach described in section 11.4 above as a response to the low-information context. Again, qualified providers would be asked to submit plans on a geographic basis aimed at making improvements relative to a counterfactual (e.g., improving the current geographic employment, independence and health cost outcomes for population segments with different disabilities or illnesses – like stroke victims under 65; people with unmet mental health and addiction problems). If there were a sub-district counterfactual, a smaller geographical basis might be appropriate.

## 13.4 Illustration: Mental health and addictions

Mental health funding is currently ring-fenced, with about 5% used by the Ministry to fund national initiatives, about two thirds paid to DHBs for services from their provider arm (largely clinical) and a little less than 30% paid to NGOs (largely support services like accommodation, home and respite

care). Providers are mostly funded on the basis of inputs supplied (i.e., beds and full-time equivalents – FTEs), with some funding to cover the cost of specific services but with no funding tied to producing results. About 3.5% of the total New Zealand population access secondary mental health and addiction services and about 8–10% of the population access primary care.

#### 13.4.1 Defining the target population segments and desired results

A mental health and addiction fund would target those people being referred for mental health and addiction services (those with mental health and addiction needs that are currently in receipt of a sickness benefit or disability pension would be covered by the rehabilitation fund and prisoners with these problems are probably better managed by Corrections). Where and when predictive tools are well developed, targeting could include those people at high risk of mental health and addiction problems, rather than just those referred for services, especially those at risk of multiple problems over their lifetimes.

In the absence of information about the actuarial cost of individuals' lifetime mental health and addiction problems, results would need to be defined in terms of measures like rates of educational achievement or employment, restoration to self-management, rates of progression to high dependency care, and rates of conviction and imprisonment.

These measures would have to be weighted by the value they create for various population segments covered by the fund. More weight should be given to these rates amongst younger people who would tend to suffer multiple periods of mental illness and addiction over their lifetimes (e.g., those children whose conduct problems are a good indicator of more serious problems as they get older). That would encourage providers to focus on child, youth and adolescent mental health.

Some consideration also needs to be given to weighting “harder cases” when those cases are most likely to generate a higher return from closer attention (e.g., case management). In the absence of this sort of weighting, asking providers to improve current performance risks encouraging providers to put too much focus on the easier cases.

#### 13.4.2 Managing the fund

The fund would again be managed in the same way as the “generic” approach described in section 11.4 above.

The qualification process will, as usual, require providers to demonstrate that they can provide a comprehensive range of services to deliver the results; e.g., not just diagnostic and treatment services but also employment placement and social support services. To be effective, providers will also need to be able to apply a range of interventions, from relatively light-touch, social-media-based interventions to intensive case management.

## 14 Implications for Budget 2016 (B16)

In terms of managing the transition to the new funding arrangements proposed in this Review, we suggest the following changes for consideration in the 2016 budget and funding round.

### 14.1 Setting the overall Vote

It is important that the suggested changes are not seen as simply a means of reducing overall health funding. Therefore, we suggest that the total allocated to Vote Health be the same as would have occurred under the existing “demo/cost” approach.

## 14.2 Funding the health and social investment pools

It is also important that we reinforce the intention to require more of the available health funding to be used for health and social investments, so we need to top slice a small proportion of the Vote for this purpose.

In order to provide time for DHBs and others to prepare submissions for funding from the investment pools, two or three potential funds need to be identified early for each pool. For example, we would suggest that the two “illustrative” funds in each pool that we have discussed in sections 12 and 13 above at least be seriously considered for inclusion in B16.

As per the “generic” model, these funds would be defined by the target population segment and location, with the definition and valuation of the results that are expected from these investments: i.e., the results that are good proxies for the actuarial liability associated with the target segment. It would make sense for the Ministry to engage with DHBs, PHOs and potential providers as to what the best proxies might be (e.g., the IPIF group has been engaged in this sort of process for their work and might be a useful starting point). Depending on the population, it may also make sense to allow for some local or regional variation in the definition of these proxies.

For the locations covered by the chosen population segments, the Ministry/NHB undertakes an initial assessment of the DHBs in those locations to determine what each DHB would need to do to qualify to submit plans for funding from the health and social investment pools and, in particular, which DHBs would be unlikely to qualify in the 2016 year. Other entities who wanted to submit plans for funding from particular funds in particular DHB districts would also need to be assessed as a normal part of the qualification process. Those DHBs that do not qualify would be required to work with the Ministry/NHB to develop a plan that would see them qualify within one or two years.

Those DHBs and non-DHB entities that do qualify would be asked to present plans for how best to deliver the desired results for each fund, in the knowledge that these plans will be assessed and the funding allocated as per the generic process described in section 11.4.

## 14.3 The priority pool

We would suggest no change to the approach adopted for funding government health targets, such as elective surgery, for 2016.

## 14.4 The foundation pool

If our suggestions about changes to the management of the foundation pool are accepted, then we would suggest moving to the new arrangements for B16, with a suspension of the qualification process if that imposed too great an administrative burden in this first year.

That would suggest engagement with DHBs over the next few months on the sort of significantly enhanced outcome and results measures that are likely to attract advanced funding and the cash flow benefits associated with that (as per section 8.3 above). We would suggest that the focus for B16 be on defining better result measures in four areas:

1. A significant enhancement of consumer and patient satisfaction measures that would allow a baseline to be set in 2016 for more weight to be applied in subsequent years. A few DHBs are well advanced in this regard and the aim should be to bring all DHBs up to the highest existing standard;

2. Improvements in a few health and independence indicators for a limited number of population segments whose health outcomes are significantly below the population average (e.g., Maori and Pacific Islander and possibly some segments of the older population);
3. Nationally consistent results for survival and restorative function for the five or ten most common conditions (e.g., prostate cancer as per section 9.1.1 above). These would need to be clinically determined with the relevant specialists engaged in defining them; and
4. Indicators of foundation system performance that are necessary and not covered elsewhere (as per section 9.1.2 above).

DHBs would then need to work up milestone measures for the agreed outcome and results, which would be used to trigger fund disbursement during 2016 (see section 8.3.3 above). The Ministry/NHB might also usefully start to identify those providers in each district that could step into any performance gaps left by DHBs that miss milestones in 2016.

During the rest of the current year, the Ministry/NHB also needs to:

1. Review the calculation of national prices to move them closer to the ideal described in section 9.2.1 above;
2. Work out how to operationalise the suggested regional and/or national clearing house(s) to better match demand for hospital-based services with the available capacity (see section 9.2.3 above);
3. Work with DHBs to identify and remove barriers to specialists working across DHB boundaries (see section 9.2.4); and
4. Initiate a “service redesign programme” with DHBs that focuses initially on those service areas where HWNZ has already completed the work with clinicians to identify service model changes that are better able to meet a significant increase in demand without a commensurate increase in funding. This would provide a standard that should be adopted unless something significantly better is already in place.

Finally, we would suggest making the changes identified in section 9.3 to improve equity of access in foundation services. There we suggest that losses of specific practices be fully made up in 2016 but that this “make up” payment be phased out over the following two years.

## 15 Further work

During our research for this Review we discovered a number of good funding practices that could be used more widely (e.g., consumer-held budgets for disability services where consumers knew a lot about what sort of service would suit their particular circumstances best) and a number of long-standing funding practices that work against transparency, sustainability and equity.

In terms of transparency, a closer look at bed- and FTE-based funding is required (and some of this funding is no more than bulk funding based on out-of-date volume and price data that has little or no accountability associated with it).

In terms of sustainability, the funding issues are far more systemic and we think the most important have been discussed above. However, some funding streams work against the sort of new service models that are most needed (e.g., section 88 – the maternity services fee schedule – does not

encourage clinical teamwork or additional attention in the community when that would pay dividends to mother and baby).

In terms of equity, there are still quite a number of funding streams and targets that encourage providers to over-service the easy cases and under-service those that are hard to reach, costly to serve or non-compliant (e.g., people that, for one reason or another, do not take the advice given, complete the recommended course of treatment or keep appointments). However, it is often these very people who would benefit most from earlier attention and a more focused approach (e.g., case management).

These funding streams are the ones that typically pay a fixed price for an intervention (e.g., immunisation) or a schedule of interventions (section 88) or have targets that can be reached most easily and cheaply by avoiding the harder cases. This can be overcome with: payments and targets segmented to focus more attention on these difficult cases; placing a higher value on preventing the outcomes that delayed treatment can cause (e.g., renal failure in diabetics); or a number of other approaches.

Not enough attention is being given to identifying those existing funding practices that are most problematic in terms of transparency, sustainability and equality and to doing something to improve these practices. Further work in this area – in addition to that covered in this Review – would pay useful dividends.

Given what we have seen, we would emphasise early attention on those funding mechanisms that impact most heavily at both ends of life: i.e., aged care (including aged residential care) and maternity services. We have reviewed these and formed a preliminary view of how they could be reformed, but a more substantive process is necessary. Although changes to accessibility in primary care as a result of suggested changes to capitation will address some of the issues in aged and residential care, this will not suffice. The objective here is to enable informed consumption.

We agree with the perspective put to us that section 88, which underpins funding in maternity care, is anachronistic. This is not to say that there are not some features of maternity care in New Zealand that are highly desirable and need to be retained (e.g., consumer choice of lead maternity carer, continuity of care and consumer influence on the way in which care is provided). However, section 88 is an unwieldy piece of legislation that does not encourage providers to adequately service those in highest need and there is no orientation to outcome, especially for children in the first year of life.

## 16 Conclusion

While the changes made as a result of the 2009 Ministerial Review Group (MRG) Report have helped, it is clear that we are not making enough progress in transforming models of care to meet the changing disease burdens we face.

While the funding changes recommended in this Review will go a long way to help, they are not sufficient on their own. The main risks are that:

1. While we are recommending a carefully phased transition to the new arrangements, the capability and capacity of both funders and providers do not develop fast enough to allow full adoption of the new approach to funding suggested here; and
2. Even if capacity and capability do develop to the required extent, the changes we have suggested do not go far enough and complementary structural change is required.

These two risks are related to the extent that the current structural arrangements of the Ministry, DHBs and private primary and NGO sectors make it harder than it needs to be to develop the capacity and capability required on the part of both funders and providers to run a more sophisticated system to fund health services.

The MRG Report envisaged a much clearer separation between the policy and regulatory function of the Ministry on one hand and a National Health Board responsible for planning and funding on the other. That suggestion was not adopted and what has emerged has not fundamentally changed the approach of the Ministry toward health funding and planning. That approach now has to change, even if the structure does not.

The conflation of planning and funding with a provider function in DHBs means that DHBs' planning and funding decisions are coloured by the need to protect their considerable investment in hospital-based care at the very time that primary and community care needs to be given greater emphasis. While the funding changes suggested in this Review will create a strong incentive to develop strong alliances with primary and community providers and deliver more integrated and patient-centric care, they may not go far enough. In this case, a separation of DHBs' planning and funding from their provider arms should be considered.

We do not come to this point lightly. Structural change is disruptive and distracting and often an excuse not to tackle more difficult and subtle problems. However, MRG recommendations aimed at encouraging the sort of alliances among primary, community and secondary providers necessary to deliver really integrated, patient-centric care were not fully implemented and at least part of that is due to the lack of sufficient incentive on DHBs to carry it through (see, for example, MRG recommendation (d), p. 18). That is not to deny the progress that has been made, especially by some DHBs. However, the gap between what we have and what we need is still very wide and we did not meet anyone who was confident that the gap would be closed at current course and speed.

Finally, the way community (and to a lesser extent primary) providers of health and other social services have been funded has fragmented the sector and focused its effort on securing short-term funding for elements of capacity or service, rather than encouraging the development of a sector with the capacity to deliver outcomes for consumers by delivering the full range of well-integrated services necessary to deliver those outcomes. The sharp end of the delivery has been the tail end of the funding process, rather than a real partner in service design and development.