



DHB Sector Financial Sustainability

July 2009

Contents

Summary of Recommendations	3
Introduction	5
Part A: Financial Sustainability - A "Banker's Perspective"	6
Appendix 1: "Common Wisdom"	12
Appendix 2: Capital Allocation Process	18
Part B: Financial Sustainability - Sector Feedback	23
Part C: CHFA Recommendations	32

SUMMARY OF RECOMMENDATIONS

The CHFA is concerned that our health system is on an unsustainable financial pathway, with a pressing need to work at containing future expenditures within affordable levels. With the likelihood of even more difficult financial times in prospect, we have prepared two papers to inform our role as “banker to the sector” and in the expectation that they will contribute to the debate about how we as a nation might achieve such cost containment.

We have assembled these papers into this one report, presented in three parts:

- Part A: Financial Sustainability – A “Banker’s Perspective”
- Part B: Financial Sustainability – Sector Feedback
- Part C Recommendations

Our recommendations are as follows:

Implement short-term changes to the capital allocation process:

- The Ministry to develop draft “top down” national plans for services and capital investment (logically, using the same templates currently used by DHBs), including anticipated capital requirements over the next five financial years
- DHBs to update their individual plans for services and capital investment, including an indication of the major investment intentions over the next five financial years (equivalent to the “strategic business case analysis” currently provided to the National Capital Committee)
- A moratorium to be placed on future requests for approval to the National Capital Committee until such national and DHB plans have been drafted, significant differences identified, and appropriate ways forward developed (a timeframe should be specified – given the apparent improvement in such planning over the past year or so, a moratorium of no more than 6-9 months would appear adequate)
- A new capital approval / allocation process to be developed, with the following features:
 - There should be an annual review of each DHB’s multi-year (at least 5 years) capital intentions plan, with details of major projects highlighted
 - The sum of individual capital intentions should be compared against the Ministry’s notional “National Plan” and Treasury’s indication of the likely new capital availability over the period, with major differences noted and sent back to DHBs for re-scoping
 - The process should be distanced from political processes as much as is practicable – in particular, the body which analyses, approves, and manages the appropriation for DHBs’ new capital intentions should be independent of the Ministry; preferably, it should also be authorised to approve projects within each year’s appropriation without further Ministerial sign-off

Establish a permanent independent “think tank” (broadly analogous to the UK’s King’s Fund), charged with developing recommendations around sector design and practice to maximise health outcomes in a financially sustainable way:

- “Financial sustainability” to be defined in terms of long-term total health spending as a percentage of GDP

- Membership to include representatives from at least: clinical leadership (from DHBs and/or professional Colleges), DHB management, external researchers, and (at least initially) a Crown financial representative (eg. Treasury and/or CHFA)
- Initial focus to be on the development of an institutional framework and decision-making processes capable of being implemented within 1-3 years – in particular:
 - Promoting a “supply focus” for healthcare provision, rather than a “demand-focus”
 - Clarifying the role and functions of the Ministry
 - Determining the appropriate number, function, and representation of local Health Boards (eg. District, Regional, or other), including linkages to non-government providers
 - Developing high-level sector metrics (eg. types of healthcare facility, populations to be served by each, etc.)
 - Recommending improvements to capital asset management, including ownership and control (central/local, public/private), and new investment decision processes

Implement a short-term “financial work-out plan” for the sector:

- Establish an independent “Work-Out Committee” to co-ordinate, control, and report on the various remedial activities currently in progress within the sector, based on the over-arching objective of cost control
- Identify any current sector initiatives whose focus is sufficiently strategic to warrant development through the above “think tank” rather than the Work-Out Committee

INTRODUCTION

1.0 Background

CHFA is charged with bringing a “banker’s perspective” to the assessment of DHBs’ financial position. Although this assessment is primarily directed at individual DHBs, broader trends with the potential to undermine the financial sustainability of the sector as a whole are also considered.

In recent months, CHFA has highlighted a range of such sector-wide issues, through its reporting to Ministers, briefing papers, and responses to direct requests for information and advice.

Over the same period, DHB CEOs have raised “capital” as a significant financial problem facing the sector. Of immediate concern appear to be issues relating to the replacement / upgrade of major DHB assets – specifically:

- the apparent difficulty in nationally prioritising capital investment proposals
- the inability of many DHBs to meet the associated capital cost of proposed investments (that is, interest, depreciation, and capital charge) within current funding levels, and
- the inability of the Crown to meet the construction cost of “required” projects within the current capital envelope

Interestingly, although the existence of such “symptoms” is widely acknowledged, the underlying “cause” (or set of causes) to be addressed is more difficult to define – for example, DHBs’ ability to meet the capital cost of major investments may be influenced by any or all of poor planning, inadequate prior provisioning, funding shortfalls, operating inefficiency, over-provision of services, or others. In turn, each of these may have a range of possible causal factors.

Perhaps unsurprisingly, numerous issues are commonly raised as “key problems” for the sector, ranging from *too much* central control (eg. DHBs unable to materially change their service mix) to *too little* central control (eg. inadequate national planning of services or assets), with a variety of revenue, funding, and balance sheet issues in between. A similarly wide range of potential solutions has been suggested.

Overall, a simple “problem statement” does not appear to exist as a point of focus for the sector’s various remedial activities, raising the risk that current efforts to improve sector finances may fail due to excessive fragmentation, inadequate co-ordination, and undue focus on proximal symptoms rather than ultimate causes.

2.0 Purpose

This Report is therefore intended to contribute to the debate about the future financial direction of the sector (particularly the work of the Ministerial “Horn Committee”), including the recommendation of specific actions.

The Report combines two separate CHFA discussion papers – Part A contains CHFA’s relatively narrow “banker’s perspective” of the issues, as distributed to senior sector participants in late May 2009; Part B summarises the feedback received from these participants, together with CHFA’s recommended way forward.

PART A: FINANCIAL SUSTAINABILITY – A “BANKER’S PERSPECTIVE”

This Part A is intended to:

- Capture the “common wisdom” around what range of potential issues and solutions exist
- Propose a clear definition of the key underlying “problem(s)” to be addressed
- Provide an initial assessment of the “common wisdom” issues and solutions (in the context of the proposed “problem definition”), and
- Present CHFA’s initial suggested way forward, for sector comment

1.0 “Common Wisdom”

As a starting point, it is considered useful to summarise some of the issues commonly cited as potential “problems” or “solutions” in discussions of sector finances. This section simply lists those which CHFA perceives to be most common – an initial commentary and assessment of each is appended (on p11).

Potential “problems”:

- Un-equal “starting points” for DHB balance sheets:
 - Different levels of debt / equity
 - Different age of asset base
- Non-sustainability of the “break-even” operating model (DHBs should be making profits):
 - “FFT” revenue growth should partially pre-fund the next anticipated asset replacement, rather than just pay for current operating cost inflation
 - “Demographic” revenue growth should partially pre-fund the next anticipated asset upgrade, rather than just pay for current operating cost inflation
 - Actual revenue increases perceived to be manipulated to force “cost discipline” rather than “long-term financial sustainability”
 - Inability to adjust service levels to achieve financial sustainability
- Inadequate national planning (services and assets):
 - Individual DHBs not incentivised to have a national perspective
 - No apparent central leadership and/or expertise
 - Apparent inequities between DHBs (access and/or outcomes)
- Inadequate control of costs:
 - Cost inflation materially above inflation and GDP growth
 - Weak bargaining position with medical staff (MECAs, locum costs, rosters, etc)
 - Inadequate workforce planning
 - Inadequate “production incentives” (benchmarking)

Potential “solutions”:

- Eliminate the capital charge
- Introduce a “one-line adjuster” (ie. a revenue “top-slice”), to spread capital costs between DHBs
- Transfer assets (ie. land and/or all fixed assets) to a central asset owner

- Change the current PBF weightings
- Introduce a centrally-owned “national plan” for services and/or assets
- Submit new capital requests by region, rather than by DHB
- Submit new capital requests on a multi-year basis (eg. next 5 years), rather than current-year only

2.0 Proposed “Problem Definition”

Although many of these “common wisdom” problems and solutions have merit, none appears to provide a useful common point of focus. Such a point of focus is considered necessary to improve the cohesiveness (and ultimate chance of success) of the range of corrective activities currently being undertaken across the sector.

It is asserted that the single fundamental problem facing the sector is cost control, and that all commonly-cited issues can be expressed in terms of cost control.

This assertion implies a need for substantial service re-configuration over the coming years (that is, a series of “efficiency initiatives” will not suffice), and is based on a simple comparison of healthcare costs with national economic growth:

- National expenditure on any item cannot grow faster than national income forever – in New Zealand, however, total health spending (of which a steady 78% or so is government spending) has grown considerably faster than national income for at least the period 1995 to 2006¹
- Similarly, the *proportion* of government spending applied to any particular sector can only grow if the proportion spent on other sectors shrinks – in New Zealand, health is already the largest single item of government expenditure, at more than 20% of total (other principal Budget items are education, social welfare payments, and pensions) [source: Treasury]
- Finally, achieving DHB cost control by simply cutting service levels would tend to increase inequities in access and outcomes, without necessarily addressing total national health spending (as those who can afford to seek private services to augment “inadequate” public ones).

From a Public Policy perspective, it is not considered useful to try to define a “*correct level*” for national health spending – for instance, it may be culturally acceptable for the government to continue to support health by spending relatively less on education or social welfare, or for total health spending to rise to 10% of national income or higher.² Nevertheless, the *rate of growth* in New Zealand health spending since 1995 is unequivocally un-sustainable over the long-term.

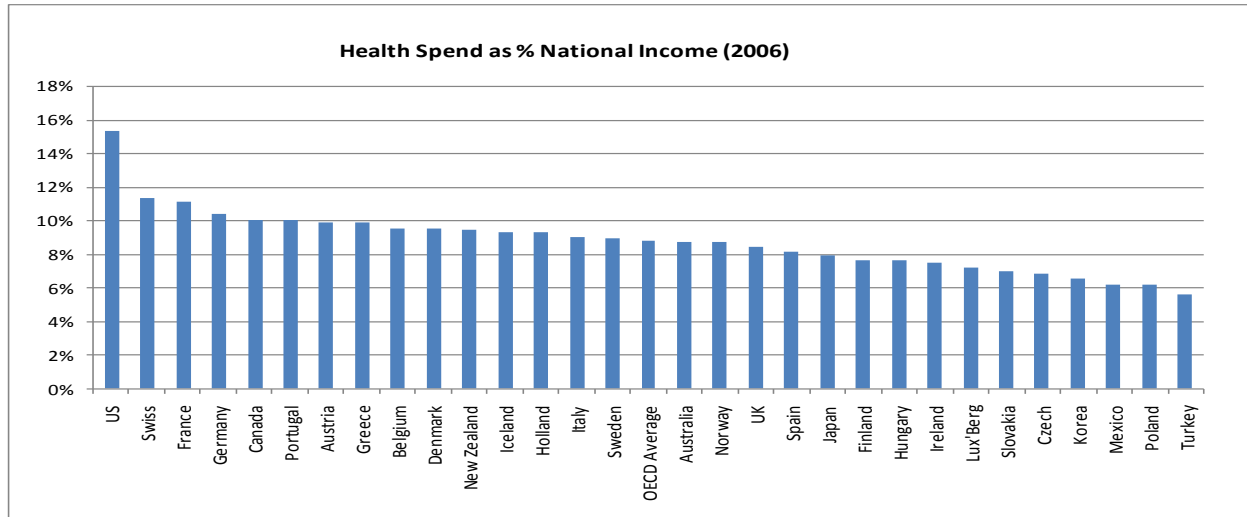
More importantly, this rate of growth may also be difficult to support in the short-term, for two reasons:

First, New Zealand already spends *proportionately* more on health than the OECD average, and more than many countries against which we typically benchmark ourselves (chart overleaf based on WHO data).

Note that the measure chosen in this paper (health spending as a percentage of national income) is considered more relevant than the more commonly used “spending per capita”, as it better reflects a country’s *ability* to spend – for example, New Zealand spends *proportionately* more than the UK on health even though it spends fewer dollars per capita, simply because it is poorer than the UK.

¹ Source: WHO. Interestingly, OECD data indicates a somewhat longer trend: The proportion of national income spent on health appears to have actually grown reasonably steadily since 1985 (having shrunk over the preceding decade), somewhat belying the common perception of “sector under-funding” in the 1990s.

² The US spent 15% of its national income on health in 2006, although less than 45% of this was government spending (raising the risk of significant inequities).



Importantly, other than the US (and arguably Switzerland, Germany and France), no OECD country spends materially more of its national income on health than New Zealand. By implication, our ability to increase health spending beyond current levels of national income appears limited.

Second, although almost all OECD countries have increased their health spending faster than national income since 1995, the extent of New Zealand’s increase has been greater than all except Korea, Turkey, and Greece. Over this period, New Zealand’s growth in health spending has exceeded its growth in national income by more than 30% (from 7.2% in 1995 to 9.4% in 2006), compared with an OECD average excess of 18%.³

The implication is that the proportion of New Zealand’s national income spent on health will continue to increase (that is, be “un-sustainable” over the long-term), even if nominal growth rates are substantially reduced. From a DHB perspective, the significant financial pressure anticipated over the current DAP forecast period as a result of lower revenue growth will still be insufficient to return the sector to long-term “financial sustainability”.

Can DHBs respond?

The underlying philosophy of New Zealand’s public health service is broadly similar to that of the British National Health Services Act 1946 – universal eligibility, free at the point of use (typically local), and funded from general taxation (not insurance).

This basic philosophy (albeit adjusted for some user-charges and ACC), combined with the current structure of 21 semi-autonomous DHBs, tends to encourage the provision of *local* health services to meet *local* needs. Such a local focus will probably struggle to adapt to the lower DHB revenue growth rates required over the coming decades, as it is not well-placed to develop *national* strategies or plans. A greater degree of central leadership appears necessary.

Clearly, a more centralized approach to health service planning and delivery raises its own problems, most obviously the risk of increased bureaucracy and lack of responsiveness to local conditions. Moreover, a major organizational upheaval, such as the re-establishment of Area Health Boards or Crown Health Enterprises, is likely to be politically (and maybe also clinically) undesirable, whilst its change management costs may outweigh any potential benefit (at least in the short-term).

Nevertheless, under current sector settings the required tension between local and national responsibilities appears to have veered too far towards the local, resulting in inadequate national planning

³ Although WHO data is as at 2006, the upwards trend in New Zealand clearly continued in 2007 and 2008, and is expected to continue throughout the current DAP forecast period despite the projected slow-down in DHB revenue growth.

and decision-making. It is considered that a more appropriate tension will need to be restored if the underlying cost-control problem is to be successfully addressed.

3.0 Draft Way Forward (for sector comment)

In summary, this Part A **concludes** that:

- New Zealand health sector practice needs to change, in order to control cost growth within (or at least close to) long-term economic growth
- Current sector policy settings (particularly the 21 semi-devolved DHBs) are unlikely to meet this challenge in a coherent manner, although major structural changes to the sector are not desirable at this stage
- What is required in the short-term is therefore a series of marginal improvements to current policy and practice – in particular:
 - the implementation of enhancements to the current capital allocation process (as described in Appendix 2 on p17), and
 - the establishment of a suitably-authorized national governance structure (a financial “Work-Out Committee” for the sector), to identify and co-ordinate other marginal improvement initiatives

As ever in such circumstances, the first objective is to achieve a consensus that each of these conclusions is correct (and, if not, what alternative is correct). At this stage, it is **recommended** that sector participants focus primarily on achieving such consensus.

If the above conclusions *are* accepted, the next steps would clearly be to implement the practical ones – that is, changes to the capital allocation process and establishment of a “Work-Out Committee”. Of these, the Work-Out Committee appears most at risk of failure, as its activities will likely overlap (and potentially clash with) existing initiatives in the sector.

Key difficulties are likely to be:

- Deciding exactly what the new body’s purpose should be – that is, should it simply be a way to co-ordinate current sector initiatives under the broad banner of “improved cost control”, or is a more holistic review of the sector required?⁴
- Deciding who should lead it (Ministry, Treasury, other?)
- Determining what current initiatives exist, and how they should be directed and developed by the Work-Out Committee
- Establishing lines of authority and accountability which would:
 - on the one hand, give the Work-Out Committee sufficient power to direct the identified initiatives and implement recommended changes, and
 - on the other hand, not undermine local authority / accountability to such an extent that responsibility for all decisions and performance can be abrogated to the central body
- Ensuring that initiatives and recommendations include consideration of the whole health sector (eg. insurers and NGOs) and related social services (eg. housing, education, CYFS, etc.), rather than just DHBs or Vote:Health

⁴ In CHFA’s view, the immediate focus should be on the co-ordination of current activities within a common objective. Longer-term, however, there will likely be a need for a more strategic review of the current sector structure (including the number of DHBs, funder/provider split, utilization of private facilities, and similar).

As a starting-point for discussion, the Work-Out Committee’s activities might be usefully divided into five inter-linked work-streams:

- **Capital allocation (that is, the decision to replace / upgrade fixed assets)** – although enhancement of the capital allocation process is listed separately above, the implementation of such enhancement should logically be overseen by the Work-Out Committee, in the same way as any other financial improvement initiative. In particular, this work-stream would be responsible for driving enhancements to:
 - National service planning (what, where, how, to whom, and at what user-cost)
 - Asset management planning (current portfolio & condition, replacement programme, upgrade programme, and funding plans)
 - The approval process for specific project proposals (the current NCC process)
- **Workforce management** – this work-stream would be responsible for driving enhancements to:
 - Employment arrangements (that is, employees, contractors, locums), including staff distribution adequate to deliver equity of access to rural districts
 - Contract negotiations (MECAs)
 - Long-term planning (including links to educational institutions)
- **Operating efficiency** – this work-stream would be responsible for driving enhancements to:
 - Clinical benchmarking (such that the data collected can be used to foster enhanced productivity, either in hospitals or in DHBs’ management of primary providers)
 - Clinical leadership (including service planning, models of care, clinical networks, and equity of access)
 - Increased use of “national standards” (where appropriate – potential appears to exist in asset design, IT systems, and supply chain practices)
- **Primary care** – this work-stream would be responsible for evaluating the effectiveness of primary health spending, including:
 - the manner in which the success of investment in primary services is measured and benchmarked, and
 - whether “successful” primary investments enhance the sector’s financial sustainability by reducing secondary and tertiary presentations
- **Governance & decision-making processes** – this work-stream would be the least “operational”, and would consider whether current governance and accountability arrangements are appropriate, and how they might be enhanced. As an example, it may be considered useful to increase the separation between long-term health planning decisions and (inherently shorter-term) political processes, akin to arrangements currently in place at Pharmac and NZ Land Transport.

It is understood that initiatives are currently under way relating to virtually all of the above bullet-points.

Less clear, however, is whether these various initiatives have a common objective (such as the control of costs within GDP growth), whether they are sufficiently co-ordinated, and whether they have sufficient authority to make a material difference within a reasonably short time-frame. Superficially, the answer to

each appears to be “no”. In some instances, there may be a number of work-groups considering the same issue effectively in isolation.⁵

⁵ Capital allocation is a good example of such diaspora – during 2008/09, relevant work was apparently undertaken by the Ministry-led Asset Management Improvement Group, the Long-Term Systems Framework project, Treasury officials, the Minister (through his “Working Group”), CHFA (as funder of most investment proposals), and the DHB CEO Forum, as well as the people directly involved (DHB staff and National Capital Committee members). The extent of co-ordination (or even common goals) between these groups is questionable.

PART A – APPENDIX 1
CHFA’s initial response to a range of “common wisdom” problems & solutions

Perceived “Issue”	CHFA’s initial response
<p>Un-equal starting points for DHB balance sheets</p> <ul style="list-style-type: none"> 1) Different size of asset base 2) Different age of asset base 3) Different levels of debt / equity 	<ul style="list-style-type: none"> 1) Weak: The hypothesis is essentially that current financial difficulty is caused by an original asset base which was fundamentally “too large” for the population it serves. It was tested by comparing relative IDCC costs (that is, IDCC as a proportion of total costs) in 2001 audited data. Result: The hypothesis is not supported by the data – none of the “top 3” DHBs in 2001 are currently “at risk”, and only 3 of the current 8 “at risk” DHBs had relative IDCC costs above the sector median in 2001. 2) Weak: The hypothesis is that DHBs with old assets in 2001 have had to make large capital investments which cannot be supported by PBF-based revenues. There is little support for this hypothesis in the data: Although 4 of the current 8 “at risk” DHBs have made a major investment since 2001, only 2 of these had an IDCC/total cost ratio above the sector median in 2008 (and then only just – they ranked 9 & 10 out of the 21), and all have a ratio lower than they had in 2001 (despite their investment). 3) Weak: The hypothesis is that current financial difficulty is caused by above-average debt levels in 2001. This is not considered logical, because (i) debt and equity are both provided by the Crown, (ii) interest charges on each are compulsory, and (iii) interest on “debt” is lower than that on “equity” – in effect, higher historic debt should have been <i>advantageous</i>, not burdensome.
<p>Non-sustainable break-even model</p> <ul style="list-style-type: none"> 1) “FFT” revenue should partially pre-fund next asset replacement, not current operating costs 	<ul style="list-style-type: none"> 1) Strong: The hypothesis is effectively two-fold: (i) that the capital cost of new assets will be higher than that of the assets they replace (because of inflation, technology, and changes to models of care), and (ii) break-even operations will not generate sufficient operating cash to support these additional capital costs, even if no other (minor) capital investments are made. This hypothesis is logical, and now appears to be well-accepted by all sector participants. The implication, however, (that DHBs should generate profits towards the end of their asset life-cycle) is not well-accepted, and is arguably not practicable.

<ul style="list-style-type: none"> 2) “Demographic” revenue growth should partially pre-fund next asset upgrade, not current operating costs 3) Actual revenue increases are aimed at forcing “cost discipline” rather than encouraging “financial sustainability” 4) DHBs can’t adjust service levels 	<ul style="list-style-type: none"> 2) Strong: The hypothesis is effectively the same as above, but applies to growth-related asset upgrades, rather than age-related asset replacement. Again, however, the problem is well-acknowledged but the implication (that at least a portion of “demographic” revenue growth should be used to generate profits rather than being spent on current services) is not. 3) Arguable: The use of “revenue banking”, “demographic adjuster caps”, and “efficiency adjusters” tends to support this assertion. It is not clear, however, whether this constitutes a “problem” – on the face of it, DHBs’ operating environment (more-or-less “cost-plus” revenues, largely fixed outputs, and apparently-imperfect cost-benchmarking) seems to encourage both a focus on cost discipline and the use of revenues as a key lever to encourage it. 4) Arguable: A DHB’s ability to maintain break-even (let alone generate a profit) is clearly hampered by its inability to materially reduce its service levels. However, greater leeway to adjust service levels may result in increased inequity of access and/or a general diminution of services through simple “cost laziness”.
<p>Inadequate national planning</p> <ul style="list-style-type: none"> 1) Inadequate “national perspective” at DHB level 2) Inadequate central leadership / expertise 3) Apparent inequities between DHBs (access and/or outcomes) 	<ul style="list-style-type: none"> 1) Strong: DHB incentives are clearly to provide local services (preferably locally), with no apparent incentive to focus nationally. It is not considered likely that a coherent national plan can emerge from a simple sum of District plans. 2) Strong: Central involvement in national planning appears to be either <i>ad hoc</i> (such as the politically-motivated funding of new hospitals or services) or simply absent (such as the apparent devolution of all service and investment decisions to DHBs without comparison to a “straw-man” centrally-managed, national plan). 3) Arguable: Although inequities do exist, it is not clear whether or not they arise from poor national planning. For example, apparent “over-servicing” in the West Coast and Otago are arguably driven by conscious (non-financial) investment decisions, rather than planning oversight.

<p>Inadequate cost control</p> <p>1) Cost inflation above nominal GDP growth</p> <p>2) Weak bargaining position with medical staff (MECAs, locum arrangements, rosters, etc)</p> <p>3) Inadequate workforce planning</p> <p>4) Inadequate benchmarking</p>	<p>1) Arguable: DHB costs have clearly risen faster than national income since at least 1996, and CHFA considers the correction of this pattern to be the fundamental challenge facing the sector over the next 5-20 years. However, this growth probably has more to do with “exogenous factors” (such as global labour supplies and government policy decisions) than poor DHB cost control – in particular, it is noted that: (i) non-DHB health costs (such as private insurance and user-charges) have risen at more or less the same rate as DHB costs, and (ii) DHB revenues have also risen at more or less exactly the same rate as costs.</p> <p>2) Strong: Although there is little data to “test” this hypothesis (other than the amount of money actually spent on MECA settlements and locum costs), it appears highly likely that DHBs are significantly weaker than the medical professions in terms of organizational unity, co-ordination of resources, incentives, and bargaining power, and have been for a number of years. Although recession may cause a shift in public sentiment (and therefore bargaining power) in up-coming MECA negotiations, there nevertheless appears to be a pressing need to amend current IR / employment arrangements. CHFA is unaware of whether a realistic alternative is being formulated.</p> <p>3) Arguable: There is clear potential for poor workforce planning to result in labour shortages and therefore reduced services and higher DHB costs. There is also a clear advantage in multi-party planning in this area (that is, including the Ministries of Health and Immigration, the Colleges responsible for clinical certifications, and the tertiary institutions responsible for training). In practice, however, it is not clear whether poor workforce planning has actually contributed to historic DHB cost growth or is simply a risk for the future.</p> <p>4) Strong: MoH has a significant database of clinical and financial variables, which can presumably be used to: (i) encourage best practice, (ii) identify & spread novel new practices, and (iii) thereby improve DHB cost control. In practice, however, it appears that this data is not being used as a primary driver of cost disciplines, perhaps because of perceived inadequate data quality. An improvement in the sector’s ability to apply benchmark data in a way which promotes behavior change (rather than just passing interest) appears warranted.</p>
---	--

Perceived “solution”	CHFA’s initial response
Eliminate capital charge	<p>Weak: The existence of a capital charge is conceptually desirable, as it sends an appropriate investment signal (that is, “don’t gold-plate the asset base if you can’t afford to pay for it”). Moreover, changing it would:</p> <ul style="list-style-type: none"> (i) simply transfer income between Health and Treasury (ie. the Crown’s overall position would be unchanged), (ii) almost certainly be recognized as such by Treasury (that is, it would be matched by an off-setting change to Vote:Health), and (iii) serve to distract attention from the sector’s underlying cost control challenge <p>At best, there may be some marginal value in eliminating the cost difference between “equity” and “debt” – either by eliminating one altogether or by increasing the interest rate on CHFA lending to match the capital charge rate.</p>
One-line adjuster (or similar) to spread IDCC between DHBs	<p>Arguable: It appears likely that:</p> <ul style="list-style-type: none"> (i) it is politically impractical for DHBs to generate the profits required to pre-fund asset replacement / upgrades, and (ii) an individual DHB operating at break-even will typically not be able to support the capital cost of a major asset replacement / upgrade <p>It would therefore seem desirable to introduce some mechanism for spreading the capital cost of major new investments across a number of DHBs (whether nationally or regionally). The simplest approach is probably a “one-line adjuster”, where DHBs’ PBF-based revenues are adjusted based on their asset age (that is, newer assets attract more revenue and older assets less).</p> <p>This approach is superficially appealing, because it would tend to (<i>inter alia</i>):</p> <ul style="list-style-type: none"> • avoid the political & practical difficulties of having to deliver a profit in order to pay for the next major investment • reduce the typical post-construction financial disruption (as the developing DHB could reasonably expect to continue to operate at break-even), and • improve transparency between the amount of revenue available to meet current operating costs and the amount which should be set aside to pre-fund future capital investments – in effect, DHBs with growing populations and/or aging assets (such as Counties-Manukau & Otago, respectively) would receive less operating revenue, rather than being required to generate a profit

	<p>The “one-line adjuster” approach raises a number of difficulties, however. including:</p> <ul style="list-style-type: none"> • the need for increased independent (potentially central) oversight of facility design, because the developing DHB no longer has to pay for “gold-plating” • the need to manage the inevitable unproductive wrangling around marginal details – likely examples include: how much of the sector’s capital cost to “top-slice” off PBF (and how to subsequently allocate it); which assets to consider in the calculations; the potential impact on IDF pricing, PBF weights, and the “tertiary adjuster”; whether DHBs should retain decision rights around depreciation rates and “minor” capex spending; how to manage surplus operating cash flows (which would tend to be large at the start of the asset life-cycle, and minimal at the end); and how to manage the inevitable transitional period (during which the likes of Counties and Otago would run deficits whilst Whanganui and Wairarapa would operate surpluses) • the fact that this approach does not address the sector’s fundamental challenge of cost control within GDP growth (that is, the sector as a whole operating at break-even will still require on-going increases in revenues to pay for sector-wide investments – the one-line adjuster may be a good answer to a problem, but it’s a different problem)
Change in PBF weightings	<p>Arguable: As for the “one-line adjuster” above, there is clearly some potential benefit in improving the current PBF weightings (if only because no such system is ever likely to be “perfect”). However, the extent of such benefit needs to be kept in context. In particular:</p> <ul style="list-style-type: none"> • weightings are already subject to regular review (that is, it’s not clear what this proposed “solution” actually means, other than perhaps just “do it better”), and • changed weightings just re-allocate funding within the sector, and do nothing to address the sector’s fundamental challenge of cost control within GDP growth
Central planning of services and/or assets	<p>Strong: There appears to be inadequate current tension between local planning (with its emphasis on local assets and service provision) and national planning (with its emphasis on available resources and funding).</p> <p>Care should be taken, however, to ensure that improvements to national planning simply serve to restore this tension, rather than to replace a “too local” outlook with a “too central” one.</p>

<p>Central ownership of land and/or buildings</p>	<p>Weak: It is unclear what purpose would be served by central asset ownership. It seems likely that any potential improvements (in areas such as asset planning, standardization of design / models of care, and spread of capital costs across the sector) could be delivered without a change of ownership, while such change would inevitably introduce a range of new problems (such increased bureaucratic administration, unclear responsibility for maintenance and “minor capex”, unclear accountability for service performance, etc.).</p>
<p>New Capital requests submitted by region, not by DHB</p>	<p>Arguable: It appears useful to have a Regional step between District and National planning perspectives. Although Regional bodies currently exist, the effectiveness of Regional planning (for services, labour, or assets) is doubtful – in particular, Districts are not adequately-incentivized to “block” a neighbour’s proposals if it has minimal direct impact on their own operations. Adoption of Regional bids for capital should improve this incentive, as it would create a more explicit trade-off between what central funding is allocable between neighbours.</p> <p>Such Regional bids would not avoid the need for central leadership – in fact, the risk of intra-Regional “stalemate” may be increased if it is clear that approval of one DHB’s proposal will result in no more capital being available for its neighbours.</p>
<p>New Capital requests to be multi-year (eg. 5 years), rather than current-year only</p>	<p>Strong: The “one-year-at-a-time” approach under the current NCC process is clearly inadequate, and multi-year requests would therefore be an improvement. However, consideration would need to be given to:</p> <ul style="list-style-type: none"> • how the approval process would work without pre-committing future Crown capital funds, and • whether the process would need to consider <i>total</i> capex plans (less than half of which is estimated to be captured by the current emphasis on “major” projects), and whether such expansion would make the approval process unwieldy
<p>Reduced number of DHBs</p>	<p>Arguable: It appears very likely that the current number of DHBs reduces the effectiveness of both Regional and National planning, as well as delivering poor economies of scale (especially in smaller DHBs). Larger organizational units, perhaps designed to be of approximately equal size and centred around a tertiary facility (the distribution of which might be nationally planned), would appear to be both more logical and more efficient.</p> <p>However, the cost of such structural change is likely to be great. Although it may be a viable longer-term objective, a focus on those cost controls which can be achieved under current structures appears to be a more logical starting-point.</p>

PART A – APPENDIX 2

Capital Allocation Process (assessment & suggested enhancements)

This Appendix is a transcript of CHFA's response to a ministerial request in March 2009

Executive Summary

CHFA considers that the current DHB capital allocation process is not capable of efficiently allocating the sector's capital investments, and that improvements are both required and possible within a relatively short time-frame. Specifically, it is considered that:

- **Investment plans are unaffordable:** Planned capital spending over the medium-term is significantly greater than both recent spending patterns and the amount of capital funding available. The operating costs associated with current investment plans would likely require an increasing proportion of government spending to fund.
- **The allocation process is inadequate:** The current institutional framework for making investment decisions is unlikely to deliver either a nationally efficient allocation of investment capital or a reduction in spending plans to more affordable levels. Key problems with the current system are the short time horizon (NCC prioritises one year at a time), the lack of a national perspective, and the lack of an independent decision-making body.
- **Remedial steps appear to be available:** It is stressed that CHFA's expertise is in credit assessment, not policy formulation or the provision of health services. Nevertheless, a number of conceptually simple remedial steps to improve the current capital allocation process appear to be both available and realistically achievable – in particular:
 - *Lengthen the prioritisation horizon* – submissions for approval of capital investments could include all plans for the next 5 years, not just the current year's request
 - *Improve the planning tension between local needs and national constraints* – in terms of "bottom-up" planning, submissions (and approvals) could be by Region, rather than by District (this would both support recent initiatives to enhance regional planning and strengthen the currently ineffectual regional review of investment proposals); in terms of "top-down" review, multi-year Regional submissions could be assessed against criteria which include national considerations (such as projected long-term funding, a notional "national hospital plan", or similar)
 - *Improve the transparency and independence of the decision-making framework* – investment decisions could be delegated to an independent entity, which would allocate the available capital based on an agreed set of specific criteria

Background

DHBs are responsible for developing their own capital investment plans, but all major projects (typically meaning those in excess of \$10 million, irrespective of the size of the DHB) require Ministerial approval. Such approval is informed by Ministry recommendations, which are developed through the Regional and National Capital Committees.

In theory, this process will result in a prioritisation of capital investment which is responsive to sector needs. In practice, however, the process is incomplete, as it has no robust way to either contain capital investment plans within affordable limits or ensure that actual investments are "efficient" from a long-term national perspective.

This letter outlines CHFA's views on: (i) the long-term affordability DHBs' current capital spending plans; (ii) the key shortcomings of the existing NCC process; and (iii) potential steps to improve the process.

It should be noted that CHFA's perspective is that of "independent lender", with a primary focus on financial considerations. Our views may therefore differ from those of entities with wider ownership or other stakeholder interests.

Affordability of Current Capital Spending Plans

Operationally, CHFA defines "financial sustainability" for DHBs as a level of cost growth which can be supported without having to increase the proportion of total government spending spent on health.

For capital spending, however, a simple "affordability threshold" for the sector is difficult to estimate, for two reasons: Firstly, because the impact of capital spending on *operating costs* is highly variable and usually not clearly modelled; and secondly, because *capital costs* are a relatively minor part of the total cost base – last year, for example, interest, depreciation, and capital charge amounted to less than \$550 million out of a total cost base of almost \$11 billion (for the sake of perspective, personnel costs were more than \$3.8 billion).

The sector's ability to support a certain level of capital spending is therefore critically dependent on its ability to control its more material operating costs. Nevertheless, it is considered useful to compare current sector capex plans against two basic benchmarks:

- *Historic averages:* For the four years to June 2008, the ratio of capex to depreciation across the sector was about 150% – that is, for every dollar of existing-asset depreciation, a little more than \$1.50 of new assets were bought.

Although this level of spending will tend to increase DHBs' cost base over time, it is not necessarily excessive – the effects of inflation, technological developments, and demographic change will all tend to make the evolving asset base more expensive than that which it replaces. Importantly, however, the sector's capital spending intentions over the next five years are materially in excess of this historic average (around 190%, from draft asset management plans).

- *Available capital:* Treasury has indicated that the amount of new Crown funding available for health capital spending over the next five years is likely to be no more than \$100-\$150 million per year. Given the sector's projected operating cash flows and other sources of funding over the period, this level of additional funding is unlikely to support capital spending in excess of the historic 150% of depreciation.

Irrespective of what level of capital spending is "correct" (or even "affordable"), these simple measures indicate a gap between current spending plans and both historic averages and available funding. CHFA considers that the current capital allocation process is unable to bridge this gap in a robust manner, for reasons outlined below.

Problems with the Current Process

The current institutional framework does not generate sufficient information on which to base efficient investment decisions, because its focus is too narrow. The NCC process effectively performs just two functions: **first**, to obtain comfort that DHB requests have been robustly prepared; and **second**, to

prioritise current-year requests within the funding currently available. The key function of managing *total* capital investment within *long-term* affordable limits is not addressed.⁶

CHFA understands that, since the inception of the NCC process, Crown capital funding has been sufficient to meet all DHB investment requests. From 2008, however, anticipated DHB requests will significantly exceed the available funding each year. The current process has no mechanism for managing such excess demand, and unsuccessful requests are likely to be simply re-presented in future years (presumably with a somewhat higher degree of priority, arising from the delay). The long-term prognosis is thus an ever-growing “bow-wave” of deferred investment, at ever-increasing levels of priority.

CHFA considers such poor prognosis to arise from three specific shortcomings of the current framework:

- *Inadequate prioritisation horizon:*

NCC effectively operates on a 1-year horizon, in that it only prioritises current business cases and only considers the allocation of the currently-available capital envelope. Such a short-term focus appears to have arisen for practical reasons – that is, only current business cases are fully-developed, no guarantees exist around the availability of future capital funding, and the amount of Ministry resource dedicated to the process is insufficient to manage anything more strategic than the immediate work-load.

CHFA considers that this short time-horizon is the most important of the current process's shortcomings, in that it makes it practically impossible to prioritise capital investment both between DHBs and within individual DHBs – to illustrate, consider the \$80m New Plymouth upgrade approved through the 2007 NCC allocation round:

- prioritisation “between DHBs” – the New Plymouth project was approved in 2007 with the knowledge that such approval may impact on the sector's ability to fund a Middlemore project scheduled for submission to NCC in 2008. The relative priority of the two proposals was not assessed, because they were submitted in different years. It appears inevitable under this approach that high-priority investments will be deferred (or additional capital required) because available funds have been spent on less important work.
- prioritisation “within a DHB” – the approved New Plymouth project was “phase one” of a three-phase master plan. Although the project was assessed to be affordable on a stand-alone basis, with no consequential investment required, there was no meaningful assessment of: (i) the affordability of the master plan in its entirety; and (ii) whether the required level of services could be delivered over the medium-term if phases two and three were later judged to be unaffordable. The clear risk is that this approach may result in a *de facto* pre-commitment of future Crown capital (and/or revenue), because all available resources have been consumed by an investment incapable by itself of delivering the required level of long-term services.

- *Over-emphasis on District perspectives, rather than a National perspective:*

It is considered essential that a tension be maintained between planning which is driven by local considerations (with its likely emphasis on local service provision) and that which is driven by national ones (with its likely emphasis on budget constraints and national allocation of capital).

The extent of current delegation in the sector appears to minimise this required “planning tension”, and to effectively manage DHBs as 21 individual entities rather than a single sector.

Such an approach runs three clear risks: **First**, the sum of DHB spending plans may be greater than the national funds available, without an effective mechanism for rationalisation (this is the

⁶ This responsibility appears to rest with individual DHBs, but such devolution hardly seems reasonable – local incentives to rationalise the delivery of local services in response to a claimed national constraint appear minimal; far more logical is the incentive to continue developing local plans in the local interest until increasing service priorities make funding available.

current position); **second**, services may be un-necessarily duplicated in neighbouring districts or regions (for example, the development of neuro services at Hamilton, which served to compete with and undermine the viability of both the Wellington and Auckland units); and **third**, assets may be under-utilised due to a lack of co-ordinated national services and/or workforce planning (anecdotally, Invercargill hospital, Waitakere hospital, the apparent inconsistency between Capital & Coast's NRH development and the extent of other major works in its IDF catchment,⁷ and the extent of development approved in the Midland region⁸).

▪ *Lack of a transparent & independent decision-making framework:*

Requests presented to NCC are prioritised based on a range of factors. In theory, available capital is allocated to the most “important” projects first, on the basis of this prioritisation. In practice, however, the decision-making process is somewhat arbitrary, in several respects:

- Many of the assessment factors are relatively subjective, and lack context when considered on an individual-project basis rather than as part of a long-term regional or national plan
- Projects may be approved irrespective of their assessed ranking, as a result of the more-or-less random availability of internal DHB funding and/or political considerations – in the 2008 allocation round, requests from Northland and Bay of Plenty are likely to be approved despite a relatively low assessed priority (Northland because the DHB had a large amount of cash at hand so did not require additional Crown funding; Bay of Plenty because the incoming government had committed to it during the election campaign)
- Projects may be approved on the basis of clinical necessity despite being demonstrably unaffordable, with no real consideration given to subsequent required steps – this appears likely for requests from Otago and Capital & Coast in the 2008 allocation round
- It is unclear what a DHB's reaction should be when a capital request is declined – that is, whether the request should be simply re-submitted in the next allocation round (perhaps nominally split into “phases”, to minimise the current capital requirement), whether a fundamental re-configuration of services is required, or whether a political solution should be sought

A transparent and independent decision-making process would require consideration of multi-year plans, the evaluation of such plans against projected available funds (and/or other indicator of “affordability”), and sufficient distance from the political process to avoid charges of “decision-making by lobbying”.

Potential Ways Forward

The following potential ways forward are based on the difficulties outlined above.

▪ *Lengthen the NCC planning horizon*

The most pressing current problem appears to be the simplest to address. In place of the current system of submitting detailed business cases for current projects on a stand-alone basis, requests for approval should detail *total* spending plans over a multi-year horizon. The relative merits of overall capital plans can then be assessed and prioritised within the projected availability of capital over the period.

⁷ Five of Capital & Coast's neighbours have had major developments approved since the NRH project was approved (Wairarapa, Nelson-Marlborough, Whanganui, Hutt, and Taranaki). All of these DHBs are major sources of IDF revenue for Capital & Coast (providing about 60% of IDFs and over 10% of total revenue), and its ability to at least partially pay for NRH through increased IDF flows has surely been diminished by these subsequent developments.

⁸ Major developments have been approved in recent years at each of Hamilton, Rotorua, Taupo, Tauranga, and Whakatane, all within relatively short driving distance from each other.

Draft DHB asset management plans include capex projections out to year 20, which may in practice be relatively meaningless. Projections out to year 10, however, are far less likely to be overcome by unexpected changes in demand, asset condition, or technology, whilst projections out to year 5 are considered essential if informed investment decisions are to be made.

- *Improve sector planning by developing clearer regional and national perspectives*

Regional perspectives could be enhanced by requiring capital investment requests to be submitted by region, rather than by individual DHB. This straightforward step would tend to: **(i)** reduce the current emphasis on local incentives (that is, locally-elected Boards incentivised to only consider local solutions), **(ii)** support recent Ministry initiatives to improve regional planning, and **(iii)** strengthen the degree of regional debate absent from the current Regional Capital Committee process. It would also provide a more uniform scale of operations for planning purposes, as regions will tend to be of approximately equivalent size (rather than the range of scale of individual DHBs).

A national perspective could be developed through existing Ministry initiatives – particularly the Long-Term Systems Framework, improved asset management planning (with its implied pre-requisite of improved service planning), and the development of a “role delineation” model to describe the scope and scale of hospital services. Such a perspective would improve the “planning tension” between local needs and national constraints, and would thereby improve the sector’s ability to: **(i)** maximise the efficiency of its asset base by minimising un-necessary duplication or resource, **(ii)** ration its overall investment intentions within “affordable” limits, and **(iii)** clearly assess the potential impact on services where the level of perceived “affordability” is insufficient to meet the perceived “need”.

Care would be required to ensure that the creation of the required “planning tension” does not result in a transfer of responsibility for local service and financial performance to central bureaucrats.

- *Improve the decision-making framework*

The transparency of the *assessment* process is likely to be improved by the adoption of the above suggested ways forward – for example, the relative priority of individual projects may be more apparent when considered as part of long-term regional plans; similarly, the non-approval of a particular plan will more clearly signal that a fundamental re-design is required (rather than just a re-submission next year).

The transparency of the *decision-making* process, however, will remain unchanged for as long as decisions must be made by political entities (that is, Ministers and, arguably to a somewhat lesser extent, Ministries). There is material precedent in New Zealand and overseas for the purchase of nationally-important assets or supplies to be distanced from political processes and managed by autonomous entities – domestically, through either State-Owned Enterprises (for more “business-like” activities such as electricity transmission) or Crown Entities (for more “not-for-profit” activities such as the purchase of pharmaceuticals or design and construction of a national roading network). CHFA considers that the effectiveness of public hospital investments (in terms of both allocative efficiency and transparency of consequence) would be enhanced by a similar distancing of the capital approval process from the political environment.

PART B: FINANCIAL SUSTAINABILITY – SECTOR FEEDBACK

This Part B summarises sector participants' response to Part A, and is divided into three sections:

- A list of the sector participants from whom feedback was sought
- A summary of the feedback provided, and
- An outline of other material items arising in our sector discussions

1.0 Sector Consultation

Part A was provided to the following sector participants. In a number of instances, it was circulated more widely within the respondent's organisation, and CHFA has been pleased with the resultant breadth of feedback we have received.

- CHFA Board
- A DHB Chair from each Region
- Chief Executives from each of a tertiary, larger secondary, smaller secondary, and rural DHB
- 2 senior DHB Chief Financial Officers

2.0 Summary of Feedback Received

Feedback received has been positive, with CHFA's approach typically regarded as thought-provoking and timely. A number of commentators noted its narrow focus – that is, a relatively straightforward problem definition and recommended short-term marginal improvements, rather than more substantial long-term structural proposals.

Part A effectively presented **four principal conclusions**, and sector feedback for each is summarised as follows:

Conclusion 1: *the over-arching financial problem facing the DHB sector is cost control.*

Recall that this conclusion related to New Zealand's *total health spending* as a percentage of national income, which in CHFA's view cannot continue to increase at the rate of the past 10-15 years. It therefore implies a need for substantial service re-configuration over the coming years, rather than simply a series of "efficiency initiatives" within current models of care.

The conclusion was well-supported in principle, although the need for clinical engagement in order for it to be addressed was stressed. Material feedback was as follows:

- A singular focus on "cost control" will likely be unacceptable, due to the expectations of both clinicians (particularly around safety issues) and the voting public (particularly around access and the desire to have all services delivered locally). The financial challenge facing the sector would therefore be better expressed as a balance between cost control and some service-level measure (such as patient access).

CHFA acknowledges this point, but notes that such a definition would raise two risks:

- It would tend to focus debate on a relatively cosmetic aspect of the problem definition, rather than potential solutions,⁹ and

⁹ In fact, the draft circulated to most sector participants *did* include a more "balanced" phrasing of the problem definition. As a result, material feedback time was spent debating the relative merits of "access", "equity of access", and "un-met need" as the relevant service measure.

- It would dilute the fundamental cost control message, by implying (wrongly, in our view) that lower rates of cost growth are “optional”.

Overall, CHFA supports the retention of a simple problem definition focussed on “cost control”, with the problem of clinical acceptability addressed separately.

One approach to this expectations problem might be to promote a change in “health culture”, to focus on *supply* rather than *demand*. For example:

- Current “demand culture” is (arguably) to identify patients’ needs, then ration the extent to which such needs are met based on available capacity and/or funding. This mind-set tends to emphasise the (irresolvable) existence of un-met demand, and the expansion of capacity and funding as the principal response.
- An alternative “supply culture” would (naively) identify the financial constraints under which the sector operates, then seek to maximise the volume of service which can be provided within such constraints. This mind-set would tend to emphasise enhanced cost-effectiveness (“outputs per dollar”) as the principal response.

Clearly, such a shift would be largely perceptual (the actual service / budgeting process within individual DHBs would not necessarily change), but the concept is considered worthy of more robust investigation.

Conclusion 2: *current sector settings are unlikely to deliver significant long-term cost controls, and greater central leadership is required.*

This conclusion generated significant feedback – in particular, there was a strong and universal view that the Ministry’s role is unclear, that its involvement in operational matters tends to stifle innovation, and that its role in strategic planning activities is inadequate.

Although such a perspective is to be expected, given the nature of the Ministry / DHB relationship, comments around the Ministry’s role and strategic input were consistent with CHFA’s own observations that the sector is effectively managed as 21 individual entities rather than a single sector.

Material feedback was as follows:

- Strategically, Ministry leadership should include the development of a high-level “vision” for how healthcare is to be delivered, including standard sector metrics such as the target population to be served by a DHB, regional secondary hospital, primary health provider/centre, and similar. Such standards should be developed in consultation with professional Colleges, to ensure clinical support. Once this strategic framework has been set, the Ministry’s role should be limited to monitoring of DHB outputs (and perhaps the co-ordination of national initiatives).

CHFA acknowledges this as a valuable concept, particularly the incorporation of primary care, involvement of Colleges, and operational freedom of DHBs. Principle challenges, however, are likely to be three-fold:

- ensuring that the “vision” is developed with financial constraints and existing resource allocation clearly in mind (unlike, for example, the otherwise well-received conceptual work done for the Central Region by TAS)
- agreeing the boundary between “useful strategic leadership” and “bureaucratic centralisation”,¹⁰ and

¹⁰ For example, should Ministry / College collaboration extend to operational standards such as beds-per-ward, staff/patient ratios, and similar? If so, who should “own” them, and by what process should they be reviewed? If not, will that result in no New Zealand standards being developed (and would that matter)? It may be useful for such metrics and standards to be developed independently, and adopted by either the Ministry or DHBs as appropriate (see the “think tank” concept discussed in Conclusion 4 below).

- similarly, agreeing which areas warrant classification as “national initiatives” (and therefore greater operational involvement from the Ministry)
- From a *planning* perspective, a key Ministry output should be “top-down” (or “NZ-inc”) national planning, incorporating explicit assumptions around population growth, demand growth, and the potential impact of evolving models of care:¹¹
 - A national services plan would stipulate what services should be delivered and (at least for tertiary services) where
 - A national workforce plan would identify the composition of workforce required to deliver the services plan, and strategies to ensure the adequate supply of skilled staff
 - A national asset plan would identify what asset configuration is required to deliver the required services using the available workforce

Commonly-cited examples of the failure of current planning processes were the continued provision of tertiary services in Dunedin, and the various locations of complex neurological and cardiac service centres across the country.

CHFA agrees that the current accountability / DAP framework is too short-term in focus, and that a more formal long-term tension between central and local planning is required. A clear challenge will be how to reconcile the inevitable differences between the Ministry’s “top down” view and DHBs’ “bottom-up” requests for capital and funding.

- *Operationally*, Ministry leadership should focus on “system failures” – that is, *imposing* a solution which is generally regarded as “optimal” but which for whatever reason the sector has been unable to implement through consensus. Particular opportunity exists around potential consolidating initiatives (such as compatible IT systems (including links to PHO systems), comprehensive shared services arrangements for “back office” functions, and improved procurement practices), which DHB collaboration has largely failed to deliver.¹²

The notion of a common procurement function is well-supported – effectively, an expansion of the current Pharmac model to clinical supplies and disposables, and possibly also non-clinical supplies. Somewhat paradoxically, there is a perceived need for both compulsion and the independence of any such function from central bureaucracy.

CHFA acknowledges this concept (particularly the need for coercion in certain circumstances), but notes the inevitable difficulty in establishing when a “system failure” has occurred and what the “optimum” solution should be. The notion of an independent supply-chain manager / procurement entity appears particularly valuable, and should be the subject of more robust consideration.

- Workforce planning requires a “new way”, in terms of both cost (industrial relations / MECAs) and supply (training / accreditation). There has been significant investment in this area over the past decade, with apparently limited result (at least in part driven by a piecemeal management approach and the tendency for political interference). Going forward, workforce management needs to be multi-disciplinary (including Colleges and universities), and to include specific initiatives relating to retention and access to foreign-trained professionals, as well as simply training.

CHFA supports this emphasis on what is by far the most important cost element in the sector.

¹¹ Although not explicit here, each of these plans would clearly need to be formulated within a specified financial constraint.

¹² CHFA does not consider this failure to be reflective of lack of effort or competence – it is simply very difficult to implement collaborative initiatives on a voluntary basis. CHFA has had first-hand experience in arranging the sector’s collective insurance policy (on the face of it, a relatively straightforward exercise), which took two years to implement and whose long-term collective viability is questionable.

- On a cautionary note, “central leadership” is not the same as “good leadership”. To the greatest extent possible, central bureaucracy should be minimised and DHBs given independence to deliver the stated policy objectives in their own way. The more operational the Ministry’s activities become (particularly in coercing shared services, central procurement, or IT systems), the greater the risk of inefficient outcomes.

CHFA concurs with this cautionary note.

- Recent emphasis on “clinical networks” is supported, but will not address the sector’s need for improved *leadership* – that is, although clinical *support* is fundamental to the success of any initiative, overseas studies (and anecdote relating to NZ cancer networks) suggest that *leadership* through “clinical networks” tend to be expensive, unproductive, and bureaucratic.

CHFA notes that one respondent suggested a strong link between the success of clinical networks and the extent to which clear clinical standards are endorsed by clinical / professional institutes. This suggests a value in encouraging the development of specific New Zealand clinical standards by domestic Colleges (although the risk is noted that such standards may not be aligned with the “cost control” objectives of this paper – see the “think tank” concept discussed in Conclusion 4 below).

Conclusion 3: *changes are required to the current capital allocation process – in particular, requests for approval of new capital projects should be submitted:*

- (i) *On a multi-year basis (at least 5 years ahead), and*
- (ii) *By Region (rather than by District)*

This two-step proposition received a mixed response – the concept of multi-year capital requests was universally supported, but Regional submission was not.

Material feedback was as follows:

- Respondents held differing views of the relative importance of capital spending: on the one hand, total interest, depreciation, and capital charge account for less than 5% of total DHB expenses; on the other, decisions on asset allocation have a significant down-stream impact on more significant operating costs (particularly staffing), because of their impact on the number, scale, and location of service centres.

There was, however, general agreement that improving the current capital allocation process should be regarded as a priority.

- There was strong support for the suggestion that the approval process should be run by a body as independent of political processes as possible (eg. an entity analogous to Pharmac or the Land Transport Agency, rather than the Ministry or Ministers). There was a perception that this entity need not be the same as that which develops a “national perspective” for service / asset planning purposes.
- Objections to the suggested Regional “bids” for capital approval were typically based on the perceived administration and lack of role clarity associated with an interposition of a Regional authority between Districts and the central decision-making authority. In particular:
 - The current Regional Capital Committee process is perceived to be of little value, as there is no incentive for it to add discipline to the process. Respondents had little faith that consolidated Regional “bids” would improve this discipline.¹³

¹³ Two opposing “stalemates” were regarded as likely: *either* (i) the Regional “bid” would simply be the sum of individual District wishes, with no additional discipline applied (in effect, a continuation of the current ineffectual Regional Capital Committee output); *or* (ii) a Regional “bid” would not be formulated at all, as

- The submission of capital “bids” by Regions rather than Districts would represent a shift in decision-making authority without a commensurate shift in accountability. The link between decision-making and accountability was regarded as crucial (that is, they should rest with either District or Regional entities, but not both).
- Regional planning has been significantly improved over the past two years (particularly in the Auckland region, where it is obviously supported by geography), suggesting that a reasonable “Regional perspective” can be developed (if perceived to be necessary) without need for a formal decision-making structure.

CHFA considers these objections to be valid, although the ability to form and maintain a robust “Regional perspective” on an informal basis remains a point of concern.

Conclusion 4: *an independent “Work-Out Committee” be established to co-ordinate the plethora of cost / planning-related initiatives currently under way within the sector.*

This conclusion prompted a mixed reaction from respondents – material feedback was as follows:

- It is agreed that the current range of remedial activity across the sector is inadequately co-ordinated (if at all), and involves significant un-necessary and un-helpful duplication of effort. A material proportion of such activity is not specifically targeted at improving financial sustainability, and none appears to be making significant progress towards that aim.
- However, there is a significant risk that the suggested co-ordinating body would lack the necessary authority to drive material progress – that is, it would become simply another committee, summarising the reports of other committees, and would add little to the financial sustainability of the sector.
- In the event that such a body could be appropriately empowered to drive progress, then:
 - It would be better run independent of the Ministry, and
 - Its impact would likely be marginal (that is, it would probably succeed in improving the financial sustainability of the sector, but would probably not address the underlying trends).

CHFA considers all of these comments to be valid. In particular, the new “remedial activity co-ordinator” must be sufficiently empowered and should not be regarded as a panacea – although its mandate may well include oversight of strategic initiatives (such as the Long-Term Systems Framework), most of the sector’s current remedial activity is likely to be more operational in nature.

With this in mind, CHFA believes there is scope for a more dedicated *strategic* body, or “think tank”, to address the fundamental strategic issues identified in this paper (for example, gaining clinical support for the “cost control” focus, and determining basic sector metrics such as the number of DHBs, role of the Ministry, and similar). Such a body should include both clinical and management representatives, as well as academics and (probably) external researchers. Some respondents noted the role of the King’s Fund in the UK health system, and this might be a reasonable approach for New Zealand to mimic in order to develop a basic sector design / institutional framework which is both financially sustainable and supported by clinicians.

individual Districts hold firm to their own wishes in priority to their neighbors’ (in effect, responsibility for the Regional “bid” would be shifted to an external arbiter, such as the Ministry).

3.0 Other Issues Arising

Respondents raised a number of related issues beyond the four main conclusions described above. In particular, issues around the “correct” number of DHBs, the current revenue-allocation mechanism (“PBF”), the appropriate asset ownership structure (including private sector involvement), and the integration of primary and secondary services were regarded as requiring resolution. A summary of these issues and sector feedback is provided as follows:

Number of DHBs

This issue typically arose when discussing the capital allocation process (conclusion 3, above). Respondents’ emphasis on the need to align decision-making and accountability appears to undermine the appropriateness of the DHB as the “local” decision-making body, because the typical DHB’s “local perspective” is heavily influenced by its interaction with its neighbours – that is, a “Regional perspective” is crucial, but there is no institutional framework for developing it.

A logical response would be to aggregate the current 21 DHBs into fewer, larger entities, which are more autonomous and thus less reliant on a “Regional perspective” interposed between the national and local ones. Such entities would also obviously tend to have greater economies of scale. For the sake of illustration, the current four Regions are each based around a major tertiary provider, serve significant populations of between 800,000 (Midland and Central) and 1.6 million (Northern), and have minimal planning reliance on each other (as indicated by current IDF patterns).¹⁴ The replacement of current DHBs with four Regional entities would therefore seem to result in a clearer national/local planning tension, although whether such entities would be “local” enough to generate innovative responses to local needs is questionable.

Respondents’ feedback was, surprisingly, somewhat ambivalent. All agreed that the current 21 DHB split was too many, but there was no consensus that a re-structure is required – material feedback included:

- The existence of significant IDF flows creates a pricing tension between the payer and receiver, which tends to encourage cost efficiencies in the providers of IDF services. Such cost discipline may be lost if IDF flows are minimised.

CHFA acknowledges this point, although the extent of current pricing discipline is uncertain (given that prices are typically set through the National Pricing mechanism, rather than bilaterally).

- Larger “local” entities would tend to result in a reduction in local responsiveness and innovation, and may lead to the neglect of smaller / more isolated areas (such as Northland, Tairāwhiti, Wairarapa, and West Coast).

CHFA acknowledges a potentially significant risk of neglect for isolated areas.¹⁵ It is less certain, however, whether the rate of innovation would decrease (through lack of local responsiveness) or increase (through greater economies of scale).

- Much of the benefit of “regionalisation” arises from standardisation (of products, services, and procedures). Such standardisation could be achieved under the current DHB structure (for example, the planned centralisation of clinical systems and back office functions in the Auckland region); a change to current sector design would simply divert management focus from “value-added” standardisation to “administrative” structural change.

¹⁴ From 2008 data, the Region with the largest net IDF exposure is Midland, at 2.3% of its PBF-based revenues. This is lower than all except one of the current DHBs’ exposure.

¹⁵ This risk of “rural neglect” could be ameliorated to some extent through Board composition (for example, including geographic representation, similar to local council Wards) and appropriate Ministry output KPIs (for example, waiting list targets based on a rural/urban comparison, as well as just an overall average waiting time). Nevertheless, the focus of Regional management would inevitably be urban.

CHFA acknowledges this point. The value of a more logical institutional framework compared with the cost of change management required to deliver it is not known, and neither is the relative bureaucracy of the two structures.

On balance, the risk, cost, and timeframes associated with a sector re-structure would appear to make it an imprudent first step. Sector feedback is consistent with Part A's suggestion that immediate focus would be better placed on initiatives which can reasonably be applied within the existing DHB structure (including the development of an improved "Regional perspective").

Longer-term, however, the fundamental shortcomings of such a combined District/Region decision-making process will need to be addressed, and on the face of it a shift to a purely Regional approach would appear beneficial.

The PBF revenue-allocation mechanism

The PBF mechanism was conceptually well-supported by respondents, but its transparency in practice was commonly criticised, in one of two respects:

- Total PBF revenue increases are typically used to meet current operating costs (that is, no profits are made to provision for future asset replacement and/or augmentation). This effectively "hides" the cost of future new asset requirements, and tends to result in a short-term crises (and deficit support) when new assets are built. Suggested "solutions" include a pre-PBF adjustment to revenues (to compensate individual DHBs for their particular capital costs), or the removal of the fixed asset base from DHBs to a central asset-owning body.
- Current PBF adjustments appear to be at least in part driven by a desire to allocate a minimum inflation-based revenue increase to all DHBs (including those with static or falling populations), effectively cutting back on the amount available for DHBs with growing populations. The cessation of such distortion would tend to provide additional revenues (and quite possibly profits) to fast-growing DHBs, and greater financial pressure (possibly including shrinking PBF revenues) to slow-growing / shrinking DHBs.

In CHFA's view, all of these comments appear to have merit, but each of the potential solutions raises its own set of difficulties. It is noted that both issues are driven in part by DHBs' relatively small size, and would therefore be less material under the sort of Regional structure that CHFA supports as a long-term objective for the sector – for example (using Ministry data for 2009/10):

- *Capital costs:* the Central Region's combined PBF revenue of \$1,827 million would obviously be better able to support the capital cost of Wellington's New Regional Hospital than Capital & Coast's \$540 million
- *PBF adjustments:* current adjustments are highly variable, ranging from an 11% "under-funding" of Capital & Coast to a 48% "over-funding" of West Coast (the absolute median adjustment is more than 9%). In contrast, the largest Regional adjustment would be about 7% (the "over-funding" of Midland, based on a population share of 19.1% and a PBF allocation of 20.5%)

Asset ownership

A number of respondents raised the potential for hospital assets to be removed from DHB balance sheets, to be vested in a central “department of hospitals” and/or private sector providers. In summary:

Central Asset Ownership

The perceived benefits of central ownership are that it would:

- strengthen the service planning and capital allocation processes (or, at least, the “national perspective” of each)
- assist in the development of clinically-acceptable national standards and models of care
- improve the efficiency of the construction process (by employing a consistent team for all projects), and
- maximise the life-span of the asset base, by removing the incentive to defer maintenance

In contrast, the perceived risks are that it would:

- become overly-bureaucratic (especially in marginal areas, such as responsibility for maintenance and the purchase of minor assets)
- lack responsiveness to local initiatives, and
- risk the separation of (central) decision-making and (local) accountability

CHFA considers all of these criticisms to be valid. However, the potential benefits of central ownership appear to be substantial, and the concept worthy of further robust consideration.

Private Sector Asset Ownership

Private sector “ownership” could encompass hospital development, ownership, and/or operation. It is typically promoted on the grounds that:

- it facilitates the required replacement / expansion of sector assets which cannot be funded under the available Crown capital envelope
- it is inherently more efficient than public ownership or service provision, due to differences in decision-making processes and individual incentives, and
- it is not inconsistent with the ownership and/or operation of other parts of the health sector (indeed, hospitals’ *public* ownership stands out as unusual compared with, for example, primary health care, laboratory and radiology services, and the procurement of assets, equipment, and consumables)

CHFA’s view is that the first argument (“improved access to capital”) is not valid.¹⁶ Moreover, there are a range of *prima facie* reasonable arguments against such private involvement in essential services, typically centred on issues of control – for example: short-cuts in service quality; semi-monopolistic “price creep” (particularly for more specialised services, such as the recently-developed private cancer service in Auckland); and the “moral hazard” inherent in long-term contracts (that is, the incentive for the private party to maximise short-term profits and then enter into mid-term contract re-negotiations once it becomes too complex or expensive for the Crown to enforce its original provisions).

¹⁶ This view is based on three assertions: (i) the government’s apparent borrowing constraint (“x% of GDP”) is, in fact, voluntary (there is no statutory restriction, no financial market limit, and, despite recent attention, no restriction from rating agencies given the amounts involved); (ii) current accounting rules will likely require the private contribution to most “PPP” structures to be consolidated onto the Crown balance sheet (that is, it will still be classified as “government debt”, just relatively expensive); and (iii) the currently constrained health capital envelope is at least in part attributable to Treasury’s lack of faith in the current NCC process. In short, greater Crown funding *could be* raised, and supporting a malfunctioning planning mechanism with private capital is counter-intuitive.

Nevertheless, the potential for private sector involvement to improve operating efficiency (and the apparently incongruous treatment of hospital assets compared with other assets) appears worthy of further robust consideration, particularly if the objective is to achieve a balance of public and private provision (rather than either one or the other).

Primary / secondary integration

Many respondents noted the proportion of national health spending on primary services (together with the relative difficulty in measuring primary sector outputs), and stressed the importance of improved primary / secondary linkages in any sector “work-out plan”. Although the objective of such integration was typically expressed in terms of patient outcomes, the implied financial outcome is that a greater proportion of patients could be treated at the (relatively low-cost) primary level.

A number of common threads emerged in our discussions, as follows

- *Rationalisation of the current PHO structure* – Unequivocally, it was agreed that there should be fewer PHOs, although no clear path to achieve this was identified.

Less universally, a number of respondents cited the potential benefits of larger-scale primary health centres (that is, single sites to deliver a multiplicity of primary services, potentially co-located with hospitals, rather than the small-scale discrete operations typical of current service provision). Key challenges to this approach appear to be: (i) obtaining clinical support for the concept; (ii) maintaining adequate patient access (given the inevitable reduction in the number of service locations); and (iii) capitalising the new centres, and gaining comfort that the overall financial impact of the initiative is positive.

- *Integration of patient management systems* – All respondents highlighted the need for improved systems integration, both within the DHB sector and between DHBs and primary providers. Key challenges in addressing this issue are likely to be: (i) deciding what the “solution” should look like (that is, whether systems should be developed on a District, Regional, or National basis, and the extent to which PHOs and other NGOs should be included; and (ii) ensuring that the resultant system(s) deliver a workable solution at reasonable cost (in particular, given the almost-certainly substantial investment required, whether the *financial* benefits delivered justify the cost).
- *Integration of primary / secondary ownership* – Some respondents noted the somewhat artificial distinction between “primary” and “secondary” services, and that the boundary between the two tends to shift over time. It was suggested that the operating efficiency of both may be enhanced by managing them under common ownership.¹⁷ Such vertical integration could be under either public or private ownership.

CHFA is not able to judge the relative merits of these suggestions, although on the face of it all appear worthy of further consideration. We would caution, however, that all such initiatives should be developed within the financial context outlined in this Report – that is, investments in *primary* care which fail to deliver reduced cost growth in *secondary* care will likely be financially unsustainable.

¹⁷ CHFA understands that this concept is being developed as part of the “Canterbury Initiative”.

PART C: CHFA RECOMMENDATIONS

This Part C presents CHFA’s recommended actions, based on its own “banker’s perspective” and the feedback received from sector participants.

Implement short-term changes to the capital allocation process:

- The Ministry to develop draft “top down” national plans for services and capital investment (logically, using the same templates currently used by DHBs), including anticipated capital requirements over the next five financial years
- DHBs to update their individual plans for services and capital investment, including an indication of the major investment intentions over the next five financial years (equivalent to the “strategic business case analysis” currently provided to the National Capital Committee)
- A moratorium to be placed on future requests for approval to the National Capital Committee until such national and DHB plans have been drafted, significant differences identified, and appropriate ways forward developed (a timeframe should be specified – given the apparent improvement in such planning over the past year or so, a moratorium of no more than 6-9 months would appear adequate)
- A new capital approval / allocation process to be developed, with the following features:
 - There should be an annual review of each DHB’s multi-year (at least 5 years) capital intentions plan, with details of major projects highlighted
 - The sum of individual capital intentions should be compared against the Ministry’s notional “National Plan” and Treasury’s indication of the likely new capital availability over the period, with major differences noted and sent back to DHBs for re-scoping
 - The process should be distanced from political processes as much as is practicable – in particular, the body which analyses, approves, and manages the appropriation for DHBs’ new capital intentions should be independent of the Ministry; preferably, it should also be authorised to approve projects within each year’s appropriation without further Ministerial sign-off

Establish a permanent independent “think tank” (broadly analogous to the UK’s King’s Fund), charged with developing recommendations around sector design and practice to maximise clinical safety and output in a financially sustainable way:

- “Financial sustainability” to be defined in terms of long-term total health spending as a percentage of GDP
- Membership to include representatives from at least: clinical leadership (from DHBs and/or professional Colleges), DHB management, external researchers, and (at least initially) a Crown financial representative (eg. Treasury and/or CHFA)
- Initial focus to be on the development of an institutional framework and decision-making processes capable of being implemented within 1-3 years – in particular:
 - Promoting a “supply focus” for healthcare provision, rather than a “demand-focus”
 - Clarifying the role and functions of the Ministry
 - Determining the appropriate number, function, and representation of local Health Boards (eg. District, Regional, or other, and including the primary / secondary split)

- Developing high-level sector metrics (eg. types of healthcare facility, populations to be served by each, etc.)
- Recommending improvements to capital asset management, including ownership and control (central/local, public/private), and new investment decision processes

Implement a short-term “financial work-out plan” for the sector:

- Establish an independent “Work-Out Committee” to co-ordinate, control, and report on the various remedial activities currently in progress within the sector, based on the over-arching objective of cost control
- Identify any current sector initiatives whose focus is sufficiently strategic to warrant development through the above “think tank” rather than the Work-Out Committee