Annex 4

Terms of Reference:

Value-for-Money

Contents

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MOVING RESOURCES FROM LOW QUALITY SPENDING TO BETTER SUPPORT THE HEALTH FRONTLINE THROUGH VALUE-FOR-MONEY:

- Testing the line-by-line spending review with the Ministry to identify any additional in-depth reviews or longer-term work that will need to be addressed,
- Consideration of the Ministry's role as a manager of a range of national operational functions,
- Selectively reviewing the rest-of-sector expenditure, including DHBs, to reduce waste and bureaucracy, and improve spending quality and patient service,
- Review the reporting and accountability processes between the Ministry, DHBs and PHOs to improve focus and reduce unnecessary bureaucracy, and
- Selectively review the plethora of existing Ministerial and Ministry committees and functions.

Moving Resources from Low Quality Spending to Better Support the Health Front-line through Value-for-Money

1 Testing the line-by-line spending review with the Ministry to identify any additional in-depth reviews or longer-term work that will need to be addressed

The Ministry of Health's 5 February 2009 line-by-line spending review (the Review) covered spending by the Ministry on departmental expenses as well as non-departmental expenses managed by the Ministry (and excluded non-departmental expenses managed by DHBs). The purpose of the Review was to identify immediate savings, low priority programmes that should be discontinued, and expenditure that should be looked at further (e.g. because priority was uncertain, the programme was low value or where performance information was inadequate). The Government indicated that rolling in-depth reviews of major expenditure areas would become a regular feature of continuous improvement. The Review identified some immediate savings, some "low priority, low value" programmes for the MRG to review and a longer-term value for money work programme. The focus was on the $2.5 billion expenditure managed directly by the Ministry, rather than the roughly $9 billion DHB funding which was agreed to be out of the scope of the initial Review.

1.1 DEPARTMENTAL EXPENDITURE ($237 MILLION)

The Review identified savings of $18.8 million from the 2008/09 year i.e. 7.9% of the $237 million set out in the October Baseline Update (OBU) for producing Ministry outputs. This was generated by a cap on FTEs, an efficiency adjustment made to Directorate budgets, and phasing and deferment of work. There was no allowance for ongoing savings as a result of these actions in following years and we were unable to determine the extent to which the savings were a result of one-off factors and/or absorption of cost pressures arising from supporting implementation of new priorities. The 2009 Budget provides one useful indicator of ongoing savings from all sources net of additional pressures: budgeted departmental expenditure for 2009/10 is $217 million, which is an $8 million (3.3%) reduction, with savings in 2010/11 to 2012/13 of an additional $4.8 million, relative to the OBU baseline.

We applied two "tests" of the Review of departmental savings. First, the scope for a reduction in budgeted FTEs, without seriously affecting Ministry output. As at 31 December 2008, the Ministry had a budgeted FTE establishment of 1,675 but had not resourced to this level and so had unfilled vacancies.[1] The Ministry has since reviewed its work programme and resources in order to deliver its revised work programme based on the new Government's priorities and with a lower resource base. The Ministry is currently operating on 1,449 FTEs and this is being "locked" into the 2009/10 Output Plan and expectations, which is a significant reduction in budgeted FTEs. Second, an in-depth look at a single Directorate, the Information Directorate (ID), where we suspected there might be potential for the largest reduction in activity and, therefore, the largest potential savings. Our conclusions on this examination are included in Annex 3 and show scope for a further reduction in cost depending on broader decisions around IT strategy and implementation.

[1] The 1,675 budgeted establishment included total vacancies of 251 FTEs (although contractors were used to fill about half of these vacancies in order to help deliver the then work programme).

Looking forward, it is important to set goals for departmental expenditure that will encourage a focus on rolling in-depth reviews. The previous goal was to reduce the percentage of the health budget spent on the Ministry of Health, from 1.82% of total Vote Health in 2006/07 to 1.65% over the three years to 2009/10. Given the rapid growth in Vote Heath, this allowed for a 17% growth in departmental expenditure over this period (albeit as a response to government priorities of the time which resulted in taking on additional functions).[2] The latest goal, as set out in the 2009 Statement of Intent, is to "reduce departmental expenditure associated with the Ministry's current roles and functions." This imposes a tighter discipline on departmental expenditure going forward.

If the Government accepts our recommendations, then many of the "current roles and functions" of the Ministry will be moved out of the Ministry over time e.g. as the Ministry's management of $2.5 billion of funding on behalf of the Crown is devolved. It will be important that transferring roles and functions is associated with a reduction in the real costs of these roles and functions, including the sector-wide costs currently incurred via the numerous committees that support the Ministry's current operations, so that resources are freed up for front-line care. This will require careful scrutiny throughout the transfer.

1.2 NON-DEPARTMENTAL EXPENDITURE ADMINISTERED BY THE MINISTRY ($2,595 MILLION)

The Ministry manages about $2.5 billion of non-departmental expenditure, largely purchasing health and disability services: including disability services, public health services, nationally contracted personal health services, electives funding, maternity, mental health, emergency services, as well as a mix of child, Maori and "Other" services. Their Review identified $57.5 million savings in 2008/09 and ongoing savings of around $22 million (0.8%). It also identified a number of "low value, low priority" initiatives with a total OBU budgetary cost of about $134 million and $48.5 million of "high value, low priority" spending, with the balance of the spending either unranked or ranked "high priority".

We "tested" the initial line-by-line review process by examining all of the "low value, low priority" initiatives over $1 million and a small selection of other programmes. In terms of the lowest ranked programmes, we submitted separate recommendations to the Minister that identified one-off savings of about $115 million and ongoing savings of about $17 million. Further savings are available from this group of programmes and from the "high value, low priority" set. Our examination of other programmes identified savings opportunities that we would have ranked in the "low value, low priority" set. Moreover, some of the programmes ranked "high value, low priority" seemed to generate little health benefit net of health harms.

While the Review process was well defined and the overall approach well thought through, the focus was on identifying initial savings and low priority and low value spending, rather than a comprehensive line-by-line review of all spending. This was a reasonable reaction to the timeframe for the Review, although it does leave plenty of scope for an ongoing line-by-line process. It was also clear to us that there was little agreement from programme managers about the definition of "low priority" or "low value" and little incentive for managers to "offer up" savings in the programmes they managed. With a few exceptions, current forecasts of the likely medium-term expenditure implications of existing and new programmes were not well developed. Better information is also

[2] The Ministry notes that this includes: the enhancement of information systems development capacity (National Systems Development Programme), the focus on National Health Targets (e.g. cervical screening, HPV, electives, B4School Checks) and an increase for regulatory changes to improve patient safety (MedSafe).

required on the cost-effectiveness of existing programmes. In our opinion, these were the main reasons why only 7% of the total expenditure (and less than 5% of ongoing expenditure) was ranked "low priority." Even when low priority spending was identified, it required a lot of interaction with the relevant programme managers to be able to identify the best way for those savings to be realised.

This is an area where the Ministry has recognised the need to build a stronger central budgetary and value for money capability, so that it can engage with programme managers to help them identify and rank programmes on a value for money basis, better identify low value expenditure, and work with programme managers to extract that value. This area of capability development was identified in this year's Statement of Intent[3] and is being reflected in the development of an internal "Treasury function" working with corporate finance to form a "virtual budget team". These are all commendable initiatives to develop the capacity needed for a more constrained budget environment.

The Ministerial Group also notes that the Ministry has now developed a comprehensive five-year financial forecast model of New Zealand's health system income and expenditure (i.e. including expenditure by DHBs). This will help to inform the extent of expected productivity, performance and quality improvements and/or service prioritisation that is required to deliver within a more sustainable health spending track. This has already been usefully applied in the development of advice to the Minister on how the sector can live within a tighter funding path over the next three to five years.

A number of themes emerged from our individual programme reviews that highlight wider issues that will continue to generate low quality spending unless they are addressed. First, the tendency to fully fund new programmes from the centre and simply layer them on top of existing programmes, rather than ask DHBs to reprioritise existing programmes. This can even apply when a new programme, like the B4School Checks, is supposed to replace an existing one, in this case a less comprehensive check at five years of age. Second, and related, is the fact that devolution of such a large quantum of expenditure has stalled. This weakens the ability to make trade-offs between this $2.5 billion of Ministry funding and the $9.7 billion of funding managed by DHBs. Part of this may have reflected the policy preferences of previous Ministers, but part of it also reflects a real concern that DHBs may not make the "right" decision, that they will favour their provider arms, that their planning and funding arms are not well enough developed to manage the extra programmes and/or that they may make different decisions to each other and so do not deliver a nationally consistent approach.

[3] "The Ministry will develop an enhanced capability to assess value for money in health and disability expenditure and to report on what needs to be done to ensure a financially sustainable health and disability sector in the medium and longer term."

The recommendations made in the main paper will help address these wider issues. In particular we are recommending that a positive list be developed for those services that need to be nationally planned and funded, that this function becomes the responsibility of the National Health Board (NHB), and that the NHB develops a process for identifying when the planning and funding of services should be managed at the national, regional, or local levels. This will provide for a more deliberate consideration of what really needs to be planned and funded nationally. We are also recommending that the regional planning and funding responsibilities of DHBs be defined and strengthened which opens up a much stronger "regional option" for the devolution of services and should start to strengthen regional planning and funding capability as well as reduce reliance on individual DHB provider arms. This should allow a much faster, and more far reaching, devolution of Ministry managed NDE to DHBs over the coming year or so. Finally, we are recommending that responsibility for capital planning and funding be transferred to the NHB, the National Capital Committee be disbanded, and a much more robust and comprehensive capital planning process be adopted (including for capital expenditure on IT).

With respect to NDE managed by the Ministry, in addition to the recommendations in the main paper, the MRG recommends that:

(a) All new expenditure proposals should be accompanied by a three-year forecast of the most likely full future cost of the proposal, an assessment of the proposal's cost-effectiveness, and an indication of savings that could be released from low priority expenditure elsewhere in Vote Health to fund the proposal, and

(b) The results of the ongoing programme that the Director General has for seeking savings in key areas in both departmental expenditure and NDE and be subject to independent expert review for relatively large areas of expenditure and be completed before the associated funding function is shifted out of the Ministry.

2 Consideration of the Ministry's role as a manager of a range of national operational functions

2.1 BACKGROUND

The Ministry's current role reflects both the advisory and regulatory functions of a core Ministry and a number of national operational functions that it has accumulated as a result of the disestablishment of the Health Funding Authority and the establishment of DHBs in 1999 and 2000. These include funding and purchasing of around $2.5 billion of health and disability services that were not fully devolved to DHBs as well as a number of discrete national operations units, like the national health payments business previously known as Healthpac. These functions continue to reside in the Ministry in part because of an incomplete devolution of funding envisaged by the 2000 Act, in part due to the lack of an alternative mandated national shared services function, and in part because of the confused and conflicting expectations of the Ministry. A review of the Ministry's "fit for purpose", based on a wide range of key stakeholder feedback, conducted in 2006 identified the need to focus more on its core roles and Ministerial priorities. It also called into question the need to continue as a manager of a range of national operational functions and as a planner and funder of selected services. It identified a need for the Ministry to achieve a significantly increased emphasis on health system performance leadership, and longer-term planning development to promote sector sustainability, and to facilitate performance improvement and best practice in addition to its confirmed core roles at the time, as are now reflected within the 2009/10 Statement of Intent.

2.2 OBJECTIVE

The Ministry is being asked to do too much over far too broad a scope of activities and that undermines its effectiveness in its core roles. A clean separation of the Ministry's core functions would provide the Minister with independent advice on the performance of the various operational and purchase functions currently performed within the Ministry. This separation would also force greater clarity of roles, policy objectives and parameters, which should reduce the current level of frustration and sense of excessive bureaucracy. Devolving more funding and planning to the local and regional levels also gives DHBs more scope to make the trade-offs necessary to meet the needs of their local populations. Finally, mandating a separate national shared services agency would not only provide a better "home" for many of the operational units currently embedded in the Ministry, it would also provide an organisation for bringing together those DHB 'back office' functions that they have in common yet provide themselves, like procurement. This, in turn, helps shift resources from support functions into front-line health care.

2.3 NATIONAL FUNDING AND PLANNING (MINISTRY MANAGED NON-DEPARTMENTAL EXPENDITURE)

The original intent of the Public Health and Disability Act 2000 was to gradually devolve funding to the DHBs as their capacity and ability to collaborate developed. The Act: envisaged "...health services to be organised at either a local, regional, or national level, depending on the optimal arrangement;" it confined decision-making power to DHBs and the Ministry (acting on behalf of the Crown); and implicitly left evolution of the system in their hands. DHBs have collaborated to some extent around regional and national solutions. However, the speed and extent of collaboration will always be affected by the local interests of each of the 21 DHBs. Further devolution of funding from the Ministry will also depend to some extent on the confidence people have in the local and regional capability of the DHB planning and funding arms, as well as in their independence from DHB provider arms.

This devolution process has stalled with over 20% of the Health Vote managed by the Ministry as NDE (described in the previous section). Most other services are planned and funded locally by the DHBs. No-one we have talked to considers the current arrangement to be optimal and, as discussed in item 1 above, we have concluded that there are key pieces missing: a national planning and funding function (that is independent of the Ministry) and much stronger regional planning and funding by DHBs.

While a stronger national and regional planning and funding capability is being developed, we recommend that the Ministry be asked to work through the various policy and machinery of government issues associated with devolving all of the $2.5 billion of NDE currently managed by the Ministry. For some funding streams, like maternity, these issues are straightforward and funding and planning might be devolved sooner. Others, like disability support services, are more complex and may take the full year to work through. At the end of that time, however, the Ministry should be able to make clear recommendations about which funding and planning functions need to be moved to the proposed NHB (or other national agencies) and which should be devolved to DHBs for management regionally or locally. At that point, we would anticipate that the Ministry would no longer be performing these functions.

With respect to the longer-term management of the $2.5 billion of NDE managed by the Ministry, the MRG recommends that:

(a) Over the next 12 months the Ministry be asked to work through the various policy and machinery of government issues associated with devolving all of the $2.5 billion of NDE currently managed by the Ministry to either the NHB (national level) or DHBs (regional and local level),

(b) The funding streams that are relatively straightforward to move out of the Ministry before the 12 month period should be moved, and

(c) Unless unanticipated issues arise, all of this funding and the associated budget to manage that funding should have been shifted out of the Ministry at the end of this period.

2.4 NATIONAL SHARED SERVICES AND OTHER OPERATIONAL UNITS

Apart from the national funding functions described above, the Ministry also manages a number of national operational units: Medsafe, National Radiation Laboratory (NRL), National Screening Unit (NSU), Clinical Training Agency (CTA), Health System Reporting (previously the NZHIS), Sector Services (previously Healthpac), and Audit and Compliance. The DHBs have a number of regional and national arrangements that facilitate collaboration around functions they have in common. However, these arrangements are vulnerable to ongoing disagreement from each DHB on each issue and, as such, to individual DHBs deciding to opt out which can undermine the ongoing viability of shared service arrangements.

The main report describes the MRG's recommendation that a new national organisation be established to assume responsibility for national shared services. This includes those currently operated by the Ministry, like the national payments system (Healthpac), as well as those common back office functions of DHBs that would be better done once than 21 different times in 21 different places. For example, the success we have had with Pharmac in procurement of hospital pharmaceuticals should be able to be replicated in other areas of hospital procurement. That would certainly help free up resources for front-line health care.

The MRG has considered each of the national operational units currently housed in the Ministry and makes the following recommendations:

- **Healthpac (Sector Services – Information Directorate)** is responsible for managing the health payments system on behalf of DHBs and the Ministry funding functions – including approximately 90 million transactions each year to pharmacists, GPs, and other health and disability providers. The payments system needs to be managed in a way that: reduces the risks associated with payment error, fraud, and disruption; reduces processing costs; and provides timely and useful information to users to enable them to better manage their costs. There are potentially very significant financial gains to be made in all areas; especially in reducing these risks and improving the value of payments information. There is a lack of clarity around the size of these risks. On the basis of international evidence, the expected cost of error and fraud is estimated to be about 5% of payments, which would translate into about $285 million per annum. The Ministry cites this 5% figure but also indicates that ongoing sampling and data matching exercises suggest error rates under 1% by volume.

  Securing the financial benefits of reducing error and fraud will require both simplification of the contracts and payment process as well as some investment in automating this simplified process. While some investment in better systems is already being undertaken, securing the benefits of simplification will require the active cooperation of the funding arms of DHBs and the funding arms of the Ministry. There may also be efficiencies to be had from a closer cooperation with the payments operations of the ACC.

The Ministry recognises that managing the health payments system is not core to its role, although access to performance information remains vital. Healthpac itself would benefit from more specialist governance that included specialist payments expertise as well as representation from users who have a stake in its operation. Moreover, the Minister should have an independent source of assurance that the risks involved in this operation are being well managed.

The MRG recommends that:

(a) The Heathpac (Sector Services – Information Directorate) be moved out of the Ministry to become part of the proposed new national shared services agency, probably operating as a subsidiary with its own governance structure.

- **Audit and Compliance (A&C)** is responsible for assessing the risk of fraud, auditing claims and investigating fraudulent claims in the primary health, community, and aged care sector. A&C more than pays for itself from fraud recoveries. A recent independent review commissioned by the Ministry recommended that A&C be expanded and shifted out of the Ministry to a stand-alone entity governed by its own board made up of Ministry, DHB, and possibly independent people with counter-fraud expertise.

  Strengthening counter-fraud and financial integrity is a potentially significant source of savings. There are also synergies with the Healthpac operation. The current A&C operation needs easy access to the payments system to track claiming activity. For its part, A&C can help identify areas worthy of closer attention in the payment process and could be easily expanded to audit Healthpac systems and payments. As long as A&C was independent of Healthpac management, it could be part of the proposed Healthpac subsidiary, with direct responsibility to that subsidiary board. That board would also be able to identify if resources were better allocated to investigating fraud or trying to prevent it by simplifying and automating the payments process and/or improving internal controls within Healthpac itself. This would not be within the scope of a stand-alone Audit and Compliance Unit. Shifting A&C out of the Ministry and into a subsidiary of the NHB would also give it more freedom to develop new services and to operate in a more commercial manner.

  The MRG recommend that:

  (a) Audit and Compliance become a part of the proposed Heathpac subsidiary of the new shared services organisation, with an internal audit function and direct accountability to the Board that is independent of management.

- **MedSafe** regulates products used for therapeutic purposes and is responsible for administering the Medicines Act 1981 and Regulations 1984. These regulatory functions are core to executive government. It also operates a database of medical devices (although these are not at present regulated). It is presently co-sponsoring the development of the New Zealand Universal List of Medicine (NZULM). Presently different codes and names are used for drugs by clinicians, retail pharmacies and wholesalers. This project will provide a database that maps all medicine codes and names used by clinicians, retail pharmacies, wholesalers and importers using an international reference code. MedSafe is currently an independent operating arm of the Ministry of Health.

The planning to create an Australian and New Zealand Therapeutic Products Agency (ANZTPA) was apparently well advanced and had a number of advantages for pharmaceuticals and medical devices, including facilitating trans-Tasman trade and reducing compliance costs and ensuring an effective regulatory regime while minimising replication of work. The development of ANZTPA is dependent on the passage of the Therapeutic Products and Medicines Bill, which is currently under consideration by the Government. If the Bill is passed, then MedSafe will move to the new joint ANZTPA.

The MRG recommends that:

(a) MedSafe maintain its current status until the Therapeutic Products and Medicines Bill is passed and it becomes part of the ANZTPA. In the meantime, it would make sense to ensure that legislation allowed MedSafe to set fees to ensure cost recovery. We also recommend that the Government strongly supports Medsafe managing the NZULM when it is complete, and considers expanding the scope of MedSafe to include the regulation of medical devices.

- **National Radiation Laboratory (NRL)** The National Radiation Laboratory is based in Christchurch. Its main roles are to: regulate the use of ionising radiation sources; provide an emergency response capability in the event of incidents involving radiation sources; and provide measurement and advisory services for both ionising and non-ionising radiation within New Zealand and overseas. NRL currently sits within the Sector Accountability and Funding Directorate of the Ministry of Health.

  NRL carries a budget of $5-6 million, of which 70% is income from commercial activity and the further 30% is from regulatory fees and Crown funding. NRL anticipates returning $1 million to the Ministry of Health pool for the 2008/09 financial year. The highly commercial nature of NRL business does not sit comfortably within the core functions of the Ministry of Health. Being part of the Ministry constrains NRL's commercial operations and restricts its operational flexibility (e.g. in human resources policy).

  Our preference would be to move the NRL to the Institute of Environmental Science and Research CRI. This would provide the most comprehensive fit for the NRL. Benefits of the fit include strong compatibility with ESR roles and functions, the ability to maximise the NRL's commercial opportunities, career pathways for scientific and technical staff, and the ability to develop a research function. While the ESR does not currently have designated enforcement functions, there is a strong history of operation in a regulatory environment in both its forensic and environmental health science operational arms (especially in several important aspects related to work in radiation protection). If the NRL were to move to ESR, this would provide the Government with something more like the 'one-stop shops' available in some other countries for scientific services underpinning the public health service.

  However, there are significant legal barriers to transferring NRL's statutory functions to ESR without legislative change. The restrictions come from the requirements of the Radiation Protection Act 1965 and State Sector Act 1988 and the restrictions on delegating Ministerial and Director General powers to persons other than Ministry of Health employees. The Radiation Protection Act 1965 sets out specific responsibilities expressly for the Minister of Health, the Director General of Health and the Ministry of Health – which it appears could not be transferred to, or undertaken by, ESR without legislative change.

A new Radiation Safety Bill is currently being drafted. The existing policy decisions are predicated on the Ministry maintaining regulatory responsibilities. The main change that would be required would be to Cabinet Recommendation 2.4 – relating to the appointment of a Director of Radiation Safety, who will be appointed by the Director General and will be a Ministry of Health employee. The drafting of this new Bill could provide the Government with the opportunity to review the whole system of scientific services underpinning the public health service and investigate the 'one stop shop' option for these services.

The MRG recommends that:

(a) The NRL remain as an independent unit within the Ministry of Health in the first instance,

(b) The Ministry of Health acts to increase the commercial flexibility of the NRL, within the constraints of operating within the Ministry, and

(c) The Minister of Health considers the opportunity provided by the new Radiation Safety Bill to investigate the 'one stop shop' option for scientific services underpinning the public health service.

- **National Screening Unit (NSU)** The National Screening Unit is based in the Health and Disability National Services Directorate of the Ministry of Health, and provides leadership and direction for six national screening programmes: BreastScreen Aotearoa (BSA), National Cervical Screening Programme, Newborn Metabolic Screening Programme, Antenatal HIV Screening Programme, Universal Newborn Hearing Screening Programme, and Quality Improvement for Antenatal Screening for Down Syndrome.

  The NSU monitors the quality of screening programmes, and works with expert groups to make sure each programme is based on the latest evidence and meets high standards. Currently the NSU has 30 advisory committees covering a whole range of functions. These committees with NSU all result from previous highly political situations around screening programmes, in particular cervical screening and breast screening. The NSU recently undertook a review of all committees. Overall the review has brought about a 44% reduction in committee cost, time, and support. The MRG recommend that these committees are reviewed annually to ensure they are driven by the imperative of adding value to the programmes.

  The MRG recommends that:

  (a) The Ministry of Health be asked to consider if the NSU should remain a national service and be moved to the NHB, or if it is better to devolve its functions to DHBs to manage either regionally or locally. Unless unanticipated issues arise, this should be concluded in the 12 month timeframe for moving NDE.

- **Health System Reporting Information (HSRI – previously New Zealand Health Information Service)** The Ministry maintains a number of national repositories and databases. Many of these depend on information collected from the national payments systems. Others have been set up normally on a single disease or condition basis (renal, cancer, diabetes, etc). These national repositories and databases are generally used to provide population health statistics and trend information.

  Considering that most people will have more than one disease or condition during their lifetime, ideally these databases should be easily linked up and should provide a complete 'person-centric' view. However, this is not the case and attempts to do so have resulted in a further plethora of hybrid 'warehouses'. This situation will be further complicated as a result of DHBs starting to establish their own regional repositories. All of these repositories, databases and warehouses add to the current bureaucracy and delay in getting timely information to the sector. The transition of all these current national repositories and databases will need to follow a national 'architecture' of information sharing, so that the information is able to be shared and brought together to provide as complete a picture of the patient as possible.

  The ongoing operation and development of such large information systems needs to be unified under a more focused and specialist governance structure than currently provided by the Ministry. Taking this out of the Ministry and into a subsidiary of the proposed national shared service organisation would provide this opportunity. It would also provide a platform for providing information services to a broader scope of provider organisations, so reducing the risk of a proliferation of repositories and databases. The Ministry would need easy access to the information managed by this subsidiary, and would be one of the largest users of its services, so may need to be represented on the subsidiary board (along with other sector representatives).

  The MRG recommends that:

  (a) the repositories and databases currently maintained by the various Ministry directorates be moved into the proposed new national shared service agency, probably operating as a subsidiary with its own governance structure.

- **Clinical Training Agency (CTA)** is responsible for planning and managing the purchase of clinical training for those already eligible to practice as a health practitioner. It has a budget in excess of $120 million. The MRG notes that the Ministerial Taskforce on the Funding of Health Workforce Training has made extensive recommendations in this area that impact on the future of the CTA and these are currently under consideration by the Government.

3 Selectively reviewing the rest of sector expenditure, including DHBs, to reduce waste and bureaucracy and improve spending quality and patient service

The MRG notes that the discussion and most of the recommendations for this item are included in the main paper. There are, however, two areas that deserve more detailed consideration: Primary Health Organisations (PHOs); and a new shared services organisation for DHBs.

3.1 PRIMARY HEALTH ORGANISATIONS

The first PHOs were established in July 2002 and there are now 82 around the country. DHBs worked with local communities and provider organisations to establish PHOs in their regions. The PHOs are funded by DHBs to provide primary care services by way of a capitation formula based on the number of enrolled patients in each PHO. PHOs vary in size from as small as 3,139 enrollees, to as large as 361,346 enrollees.

3.1.1 Funding

PHOs receive their capitation-based funds from six main funding streams:

1 First Contact payments – fees payable to GPs, based on the number of patients enrolled with the GP. In most, but not all cases, the PHO simply acts as a conduit of these fees. In some cases, usually in smaller PHOs, the PHO 'top-slices' those payments to meet general expenses.

2 Services to Improve Access (SIA) payments, based on the number of High Needs Patients (defined as those of Maori or Pacific ethnicity or those living in areas with a high level of deprivation (as defined in the New Zealand deprivation index).

3 Health Promotion funding.

4 Care Plus, which is a programme with capped funding that is intended to contribute to the more intensive primary health care required by patients with high health needs (e.g. due to chronic health conditions), as compared with High Needs (defined by population) patients. There are qualifying criteria that must be met before a patient may be enrolled in this programme (subject to available funds).

5 PHO Performance Programme (see more in Annex 3).

6 Management Fees (see more below).

In 2006 the quantum of PHO funding was as set out in the following table:

Capitation-based funding	2006/07	%
First Contact	$421,505,000	71.0%
Service to Improve Access	$33,910,000	6.0%
Health Promotion	$7,754,000	1.3%
%Management Fees	$28,126,000	4.7%
Referred Services		
Pharmaceutical co-payments	$98,566,000	16.5%
Laboratory payments	$3,084,000	0.5%
Total Capitation-based Funding	**$592,945,000**	**100.0%**

The amount of management fees paid in 2006 was $28,000,000, but has increased by the first quarter of 2009 to almost $31,500,000.

3.1.2 Management fees

If the number of Enrolled Persons in the PHO is 40,000 or below, and the DHB has approved the PHOs' Management Services Plans, then the rate will be $15.1216 per person up to 20,000 and $0.8720 per person from 20,001 to 40,000. Otherwise, if the number of Enrolled Persons in the PHO is 75,000 or below the rate will be $10.7608 per person up to 20,000 and $5.2328 per person from 20,001 to 75,000. If the number of Enrolled Persons in the PHO is 75,001 or above then the rate will be $503,020.00 plus $5.8764 per person over 75,000 enrollees.

Calculations for management fees show that there are marked cost differences in the management of large and small PHOs. Not only are small PHOs unable to provide the range of services that larger PHOs can offer, there are strong financial incentives to remain small because of the scale of management fees (e.g. an average of $15.12 per head for the smallest versus $6.18 per head for the largest). Thirty-eight of the 82 PHOs have an enrolled population of less than 20,000 and their management fees amounted to $6,202,834.96 in the first quarter of 2009.

If amalgamation, federation, collaboration of some form or formal consolidation of corporate governance, clinical governance, and management services that preserved the ethos and community participation in smaller PHOs were to occur, considerable savings in management fees could be made. Development of incentives or removal of disincentives to amalgamation, federation, or collaboration should be considered.

There are defensible arguments for the retention of some small PHOs, but some incentive to share management structures is highly desirable. Any such arrangement must preserve the benefits of community participation that may be very strong in small PHOs. In fact, any configuration of PHOs should demonstrate effective corporate governance, clinical governance, and community involvement. Corporate and clinical governance should be of 'best practice' standard. Community participation can be exhibited in a variety of ways including, but not restricted to, membership of corporate governance boards, or community advisory groups, or even less formal structures in some instances. The important factor for community involvement is that the community should have influence over the planning and delivery of health services.

If the management fee were altered from the current levels for PHOs with an enrolled population of less than 40,000 people, for example, to $8 per head, and if all PHOs with a population in excess of 40,000 people maintained their current level of funding, annual savings of $3,577,430.09 could be achieved. Some of this money could be returned to PHOs for the first year in order to help them amalgamate, confederate, or collaborate in some form.

PHO annual management fees

PHOs stratified by population size	**Number of enrolled patients**	**Current management fee**	**Management fee @ $8/head to 40,000 enrollees**	**Management fee @ $8/head to 40,000, and current fee beyond 40,000 enrollees**
PHO < 40,000 a) < 20,000 b) 20,001 – 40,000	410,197 307,737 717,934	$6,202,834 $3,118,667 $9,320,901	$5,743,472	
< 40,000	3,677,040	$22,005,751		
Entire enrolled population				$27,749,223
Savings, if $7 per enrollee management fee applied				**$3,577,430.09**

3.1.3 Delegated funding

Larger PHOs and their associated Management Services Organisations (MSOs) operating with low management fees are able to provide services and infrastructure, including information management, programme management, and continuing education to nurses, administrators, and doctors. Smaller PHOs are not able to provide these components of quality performance for themselves (although some are obtaining these services contractually from MSOs).

When PHOs have the capability, DHBs need to consider delegating funding to PHOs for the provision of various services. Amongst those under consideration are pharmaceutical prescribing, diagnostic testing (including access to advanced imaging technologies such as CT and MRI scanning), and minor surgery. Scale of population numbers will be essential for successful participation in these foreshadowed activities, so further strengthening the incentives on PHOs to amalgamate or work more closely together to share the financial risks associated with delegated funding is required.

In most instances, scale is important in allowing PHOs to step up to a greater role. Larger organisations will have a greater chance of establishing and/or maintaining management establishments with the capacity and skill base to perform the functions required. Populations of between 100,000 to around 500,000 are probably required. Scale is highly desirable if there is to be an element of risk management, or simply risk sharing, in arrangements for delegated funding.

It should be noted however, that there is likely to be an optimal size for financial efficiency of health care organisations. In health care organisations overseas, the cross-over point for the intersection of reduction in financial risk with increased size of the risk pool and decline in management efficiency with increased size of the risk pool is at about the 500,000 enrolled patients level.[4] The optimal benefit of scale, in financial terms, for management of PHOs may be of that order. Only the Pinnacle and the ProCare management groups are of that order of size in the New Zealand primary care sector.

3.1.3.1 Establishment of New PHOs

In order to have the capacity to meet the objectives of moving services from secondary to primary care and managing associated delegated funding, PHOs need to demonstrate sound corporate governance and management, effective community engagement and an ability to manage the financial risks involved if taking up delegated funding. With realignment of PHOs through amalgamation or federation it is likely that, in some instances, achievement of these conditions may suggest the emergence of new PHOs. Thus, paradoxically, although the total number of PHOs must reduce, there will remain a requirement for new PHOs to form. Any barriers that inhibit the ability of GPs to leave or join a PHO would need to be addressed.

[4] Smith & Witter. (2004). ***Risk Pooling in Health Care Financing: The Implications for Health System Performance***. Centre for Health Economics, University of York: York, UK.

The MRG recommends that:

(a) The management fee paid to PHOs with enrolled populations of less than 40,000 be reduced and some of the resulting savings be used over the subsequent year to help those PHOs amalgamate, confederate, or enter into other arrangements for sharing management overheads,

(b) DHBs be advised that barriers which restrict the ability of GPs to leave or join a PHO should be abolished, and

(c) DHBs be advised that new PHOs should be permitted, on condition that: (i) establishment funding is not provided (ii) that it is the preference of health care providers, and (iii) sound corporate governance, sound clinical governance, and effective community participation is demonstrated.

3.2 A NATIONAL SHARED SERVICES AGENCY FOR DHBs

Pharmac has been successful in helping to contain cost growth in pharmaceuticals, with significant and ongoing savings. It acts as a negotiating agent for the DHBs, who have to buy off the Pharmac drug schedule on terms and conditions negotiated by Pharmac. Pharmac also assesses the cost-effectiveness of new drugs before putting them on the schedule. The budget stays with the 21 DHBs, who reimburse pharmacies who do the actual purchasing. Pharmac have to live within a notional budget negotiated with the DHBs every year. This is a useful model.

The potential gains of collective procurement are hard to estimate with any certainty. DHB provider arms are significant purchasers of goods and services with annual non-payroll expenditure of about $2 billion per annum. A reasonable proportion of that will not be amenable to savings (e.g. government charges, the need to maintain an exceptions policy). Collective purchasing that generates volume leverage on price should be able to deliver a 10% saving, so if only half of all DHB non-payroll spending could be purchased nationally then that would generate savings in the order of $100 million, realised over a number of years. This seems conservative given the DHB CEO's current target of $45 million savings in 2009/10 from a subset of expenditure items. Even when these savings are fully realised, you would expect cost growth to rise more slowly as a result of national procurement, so generating ongoing savings. There are additional gains to be had from product standardisation and through better supply chain management e.g. contract negotiation, warehousing, inventory, transport, and payments.

There are also likely to be additional gains to be had from centralising and standardising other back office functions, such as payroll and finance systems.

There should also be real economies of scale in doing common functions once, rather than 21 times, and developing strong expertise and robust processes (e.g. around clinical engagement in decisions involving standardistion of clinical supplies over time).

This presents us with a real opportunity to shift resources to support stronger front-line care.

From the senior DHB people we have talked to, there is a recognition that current collective arrangements do not work well, largely because of the difficulty of managing 21 autonomous DHBs who can opt in or out at any time. There is strong support for collective procurement and a recognition that this will mean giving up some local decision-making over procurement decisions.

An assessment of the current state of DHB procurement and supply chain practices suggests some areas of good performance, although a relatively weak overall position in terms of both collective procurement and supply chain management. Standardisation of clinical supplies is still in its very early stages.

The DHBs clearly see the benefits of collective procurement. They agreed to initiate a collective approach in December 2006 although progress has been slow and commitment uneven. They are currently working through DHBNZ on a number of projects in the clinical and non-clinical areas, with an ambitious savings target for 2009/10.

The MRG recommends that:

(a) The creation of a Pharmac-like national shared service agency with a mandate to manage the assessment, standardisation, management, purchasing, and/or supply chain management of any of the common back office functions of DHBs that are referred to it by the Minister of Health,

(b) The operational budget of this agency be funded by top-slicing the DHB funding formula,

(c) That this agency will act as an agent for DHBs and will agree with them a notional (or actual) budget for the management, purchasing, and/or supply chain management tasks it undertakes on their behalf,

(d) As long as a budget can be identified, then the Board of this agency will make the final decision on what is purchased and the terms, conditions, and prices of procured items and the management of shared services (like payroll and supply chain), and

(e) The NHB be required to establish a process for working through the entire range of common DHB back office services to identify a list of services that are best supplied by a single national provider, starting with non-pharmaceutical hospital procurement.

4 Review the reporting and accountability processes between the Ministry, DHBs and PHOs to improve focus and reduce unnecessary bureaucracy

4.1 INTRODUCTION

This paper deals mainly with the DHB accountability and reporting processes. Many of the issues facing DHBs with regard to reporting and accountability are mirrored directly in the PHO and wider primary health sector, and therefore many of the recommendations in this paper will have direct relevance to PHO and primary care provider reporting and accountability.

4.2 BACKGROUND

The current state of reporting and accountability in the DHB sector is onerous on DHBs and the sector is constrained by the contractual process, extremely detailed service specifications, and excessive reporting requirements. To understand the current process and then develop their recommendations on the reporting and accountability processes, the MRG analysed Ministry of Health reporting documentation in detail and wrote to all DHBs to ascertain their views of the current state and suggestions for a new process that improves the focus of the reporting and reduces the unnecessary bureaucracy.

4.3 CURRENT STATE

The current state of reporting and accountability has a number of different processes and levels. Some of these are direct accountability processes from the New Zealand Health and Disabilities Act 2000: Crown Funding Agreement (CFA) (section 10); and District Strategic Plan (DSP) (section 38); District Annual Plans (DAP) (section 39); Statement of Intent (SOI); and Financial Statements and Annual Reports (section 42 which refers to the Crown Entities Act 2004). Others include the Minister of Health's Health Targets, Indicators of DHB Performance (IDPs), Operating Policy Framework (OPF) and Crown Funding Agreement variation reporting. In addition there are Hospital Benchmarking measures which the Ministry of Health collects quarterly.

DHBs clearly articulated the main reporting and accountability burdens as being:

DAP and SOI. Many of the issues around these two documents can be described as "two acts, two separate interests". Requirements for the content of each vary considerably. For the SOI the Office of the Auditor General's focus is on monitoring the performance of DHBs as the health arm of public service, within the context of the Government's outcomes for the nation. The SOI adopts an intervention logic model of inputs→outputs→output class→contribution to priorities, and strategic goals→social outcomes, whereas the DAP uses a different approach and terminologies and is more generally supposed to be the DHB's plan which demonstrates how they are implementing the Minister's Health Targets and the New Zealand Health Strategy. There is a strong theme from DHBs that while the DAP's main purpose is supposedly for the local DHB they remain the vehicle for articulating the Ministry's requirements with very little local value. The requirement to prepare the two separate documents clearly results in more staff time and resources, adding to the bureaucracy.

The Minister's Health Targets and Indicators of DHB Performance (IDPs). The Health Targets outline the Minister's high-level expectations for the sector. The aim of the IDPs is to cover off reporting requirements against delivery of the New Zealand Health and Disability Strategy. The IDPs are a significant issue for DHBs in a number of ways:

- They question whether the IDPs being collected are the ones that best measure both DHB performance and/or health improvements,
- The number of IDPs adds onerous reporting requirements – the 2008/09 requirements contained 34 separate measures, some of which required more than one report and with total sub-measures over the full year of 2009, and
- Lack of clarity around the use of the information. While the Ministry outlines the usefulness of the information to ensure the New Zealand Health Strategy is being delivered, it is clear that a more efficient and streamlined process is required.

For the 2009/10 year the Minster decreased the number of Health Targets from ten to six and the Ministry decreased the overall IDP reporting requirements, and the sub-measures, and reduced the reporting times across the year. Overall this equalled a reduction in reporting requirements (see table below).

Section	08/09	09/10	Reduction	% Reduction
Health Target	73	36	37	51%
IDP	136	104	32	24%
Total	209	140	69	33%

The information going out to DHBs was poorly presented in a 99 page electronic document that mixed indicators with reporting measures and generally did nothing to add clarity to the reporting and accountability process. There was also no indication of the changes that would be implemented to the CFA variations (see next paragraph) which were an important aspect of the reporting reduction. The document was not well received by DHBs who articulated clearly that from their perspective there is no real reduction in reporting requirements and in fact their initial reaction was that there would be increased requirements to meet new reporting measures. However, further analysis by DHBs indicated they recognised a 27% reduction in IDP reporting. The process currently misses any opportunity to move forward together as a sector and appears to be a Ministry-driven process, rather than one in which there is sector agreement on the most relevant indicators for and process of reporting.

CFA variations. CFA variations are individual contracts between each DHB and the Crown. Each new initiative funded by the Ministry in its 'funder' role has attached reporting requirements that appear totally out of proportion to the dollar value of the contract. The type of information required is extremely prescriptive and appears to DHBs that the Ministry staff is micro-managing them as opposed to wanting assurance the contract is carried out in a timely and effective manner. In addition there is no cross-moderation across the Ministry to curtail the reporting burden.

The Ministry provided a snapshot report of CFA variations for Quarter Four 2007/08 which showed that 118 CFA variations were required to be reported on. DHBs provided reporting templates which showed the depth of these 118 variation reports. The total picture provided clearly outlines the onerous burden that CFA variation reporting puts on the sector with very little obvious benefit.

The MRG notes that the Ministry has made good progress in two areas:

- Reducing overall IDP reporting requirements by 30%,
- Revising the CFA variation reporting for the 2009/10 year, and
- In future all CFA variations will be on a certification and exceptions basis.

If boards meet the service and/or output requirements a certification statement is all that is required. If boards have not met the requirements an exception report will be required. This process will commence with all new variations in the 2009/10 year and the Ministry will start work on changing all variations so they align to the new certification and exception reporting.

Hospital benchmarking.The Ministry collects 18 benchmarking indicators quarterly which are included in their snapshot report. It would appear that this process is about sharing information rather than a process to improve productivity. The DHBs have started to pay more attention to benchmarking themselves. Their approach, which includes good comparative data and a forum for effective discussion amongst clinicians about the results and the sorts of practice changes required to deliver improvements, has much to recommend it.

All players in the sector acknowledge the need for a rigorous and transparent accountability process with timely reporting mechanisms. Without exception the DHBs who replied to the MRG request for information indicated their willingness to be part of a process which streamlines accountability and reporting into a more meaningful framework. There is acknowledgement that attempts have been made to adjust and streamline current arrangements. However the very clear message is that reporting and accountability processes still place an onerous burden and high transaction costs on the sector.

The MRG notes that while the Ministry has made good progress, DHBs still consider that the reporting and accountability process is overly onerous and are willing to contribute to a process that streamlines accountability and reporting into a more meaningful framework.

Changes to version coding. Information collected from the sector for national databases is subject to changes from time to time. When that happens the Ministry of Health will work with the sector to effect these changes. The main issue that needs addressing is the capacity to implement changes by the sector and their vendors.

The most common of these changes is the annual '1 July Changes' otherwise known as the National Collection Annual Maintenance Programme (NCAMP). The national databases covered by NCAMP are:

- National Minimum Data Set (NMDS) – hospital inpatient data,
- National Non-Admitted Patient Collection (NNPAC) – hospital outpatient data,
- Programme for the Integration of Mental Health Data (PRIMHD) – mental health and addiction data on outcomes at local, regional, and national levels collected across DHB and NGO service providers, and
- National Booking Reporting System (NBRS) – information by health specialty and booking status on how many patients are waiting for treatment, and also how long they have had to wait before receiving it.

The reasons for changes includes version changes to inpatient output classification codes, additional information to be collected like waiting time for outpatients, and changes to elective services from specific procedures to a collection of all procedures for a specialty. There is a timetable for NCAMP changes which extends over a period of 12 months. To date a number of these 1 July Changes have been delayed due to DHB vendor inability to deliver a properly tested version for timely implementation by DHBs. This can be overcome by including consultation between the DHB's patient administration system vendors and other sector stakeholders earlier in the process (October) rather than waiting until late December. This earlier involvement would give vendors an additional two months which will make all the difference in ensuring timely delivery of the 1 July Changes.

The MRG recommends that:

(a) With respect to the National Collection Annual Maintenance Programme, there is consultation between the DHB's patient administration system vendors and other sector stakeholders earlier in the process (October) rather than waiting until late December.

Changes to versions of national databases driven by DHBs, like the national payment systems, also need addressing. Although there are processes in place for DHBs to inform the Ministry of Health, the issue is one of timeliness and the complexity of DHB contract requirements. The recommendation is for a review of what is needed for payments versus what is required to monitor contract performance. This review should feed into any future option for updating the national payment systems. Payment methods should be simplified (a set of standard payment options) and any non-standard payment requests should be the exception and strategically approved.

The MRG recommends that:

(a) DHBs are clearer about what is needed for payments (versus monitoring contract performance) and that payment methods are simplified in order to reduce the cost and complexity of the payments system.

Apart from the above changes, the broader sector is also subject to changes for other national databases such as the National Immunisation Register, the PHO Performance Programme, and the National Screening Register. As part of the broader recommendation to review the current accountability and reporting indicators, the opportunity should be taken to look at developing "integrated sector annual changes to [the] national collections programme." The priorities for these changes need to be strategically driven to meet National Health Plan priorities and timing.

4.4 PATHWAY FORWARD

The main objectives for any accountability and reporting process is to ensure that DHBs and other providers are delivering the services required, within the budgets they are given, without building up service or budget pressures for the future and while properly managing their risks. From the centre providers need clarity around the Minister's Health Targets and service priorities and the funding parameters. Then the accountability and reporting framework should be based on the information they need to run their business and deliver on the Minster's expectations.

Overall the aim is to move to less reporting and a more constructive engagement process with the funder. This process has started between the DHBs and the Ministry with the introduction of the certification and exception reporting for CFA variations. DHBs have indicated a strong desire for a streamlined process that has less time and resources consumed by reporting and compliance costs.

District Strategic Plan. This plan outlines the DHB's strategic intent for the next five years, is outcome focused, and provides the context for the SOI. The DHB planning cycle ensures regular reviews (three-yearly as a minimum), and the plan updated in response to any change indicated.

SOI. More work needs to take place to align the DAP and SOI processes so one document serves the purpose of both or at best the SOI becomes an addendum to the DAP.

DAP. Focuses on: the Minster's expectations; national; regional; and local priorities; and also reflects the current year's actions leading to the outcomes outlined in the DSP. The Minister would develop a simple set of requirements and DHBs would drive the plan. Included in the Minister's expectations would be the six Health Targets and no more than10 service priorities. DHBs will ensure that they have clinical sign-off that the service and quality dimensions are in place, financial sign-off that the plan can be delivered for the dollars, and risk management assurance that the risks are properly covered. Reporting would be quarterly for the indicators, plus a quarterly certification and exception report for the rest of the DAP.

CFA variations. To be entirely certification and exception reporting.

PHO and other community based providers. The issues around reporting and accountability within the primary and community health sector are the same as those that affect DHBs. The current contracting environment has led to the development of an onerous range of reporting requirements for primary and community providers that contract with DHBs, which mirror the requirements that the Ministry of Health has developed at the centre. The MRG has been advised that alongside the reporting and accountability requirements there are also a high number of audits carried out on individual providers that are out of proportion to the contracted amount of the service. Similar audits are often carried out by multiple agencies on the one provider. Both of these are compounded by the annual contracting cycle, which for small organisations takes too much of the focus of key personnel off delivery of health care and onto maintaining the bureaucracy.

The whole thrust of Better Sooner More Convenient is to reduce bureaucracy and put care closer to home. An important step for primary and community providers will be developing national agreement around issues such as longer-term contracts which would provide stability for smaller providers and ensure a stronger base to attract investment funds to balance their government funding. This will reduce contractual reporting so reporting requirements are more streamlined and work from a certifications base as is now functioning for DHB Crown Funding Agreement variations. Finally auditing requirements will see DHBs prepare an audit schedule that dovetails all requirements and with one agency managing the audit process, hence reducing transaction costs and time for small providers.

Specifically for PHOs, many DHBs reported that it would be useful to have more flexibility built into National PHO contracts to facilitate locally agreed initiatives.

The MRG recommends that a:

(a) Working party is established with a range of sector representatives to develop a national framework for contracting, reporting and accountability that streamlines processes and ensures clear, timely accountability e.g. to align the DAP and SOI reporting, to investigate how the certification and exception basis can be used more widely, to agree the process for identifying key IDP reporting requirements, and to develop the DAP into an action-orientated document that is more relevant to DHB priorities and performance.

5 Selectively review the plethora of existing Ministerial and Ministry committees and functions.

5.1 INTRODUCTION

The MRG terms of reference require, under item (c) 'Moving resources from low quality spending to better support frontline services through improving value-for-money', that the MRG "selectively review the plethora of existing Ministerial and Ministry committees and functions."

This paper comments on the current advisory committees and makes recommendations for both the future of these committees and guidelines for the establishment of any further committees.

5.2 CURRENT STATE

In a briefing to the Minister of Health, the Ministry of Health outlined the role, importance, and effectiveness of the 142 committees that provide the Minister or the Ministry of Health with advice. These 142 committees cost approximately $8,086,000 per annum and utilise nearly 47 FTEs in staff time to service. There appears to be no consistent process that effectively manages the establishment of committees, which is reflected by the differing approaches to issues such as terms of reference, term of life, selection of members, budget apportionment, review processes, and the role of the committee. The resources above only take into account Ministry internal resources and in no way reflect the true cost to the sector of running all these committees. Currently most committee members are paid on a standard rate agreed by Cabinet[5] but there are some committees that pay above the standard rate to access the advice they require. Real costs would include the salary, time, and the opportunity cost for the DHB and other provider personnel who attend. There is also difficulty in assessing the real cost of servicing these committees to the Ministry of Health as the Directorates were unable to provide servicing cost and FTE requirements for many of the committees.

In their advice to the Minster, the Ministry of Health indicated that of these 142 committees:

99 were highly important of which:

- 76 were rated as highly effective,
- 17 were rated as moderately effective,
- One was rated as having low effectiveness, and
- It is too early to establish the effectiveness of five of these committees.

36 were of medium importance of which:

- Three of these were rated as highly effective,
- 27 of these were rated as moderately effective,
- Five of these were rated as having low effectiveness, and
- It is too early to establish the effectiveness of one of these committees.

[5] http://www.dpmc.govt.nz/Cabinet/circulars/co03/4.html

Seven were of low importance of which:

- None were rated as highly effective,
- One was rated as having moderate effectiveness, and
- Six were rated as having low effectiveness.

In undertaking this process the MRG has received information from the Ministry of Health on 157 committees in total and has divided them into the following categories and provided recommendations for each category:

- Statutory Committees,
- Ministerial Advisory Committees,
- Ministry of Health Advisory Committee: Areas with a high number or high-cost committees, and
- Ministry of Health Committees: Others.

The MRG notes that of the 157 committees reviewed:

- 23 committees have been disbanded since the original Memorandum to the Minister of Health,
- 23 committees are due to be disbanded when their project timeframes are complete,
- Two are on the committee list but have not yet been implemented,
- NSU has reviewed all its committees and decreased the number, and revised the terms of reference and number of meetings for the remaining committees. Twelve of these committees have now become Expert Panels and will meet between one and three times per year for specific issues, and
- Two are not Ministry of Health committees.

The MRG recommends that:

(a) Four committees have their Terms of Reference and membership refocused to fulfil the new mandate outlined in the MRG report,

(b) 16 committees be disbanded,

(c) 16 committees be disbanded and their functions transferred to the NHB,

(d) Seven committees be merged,

(e) Five committees be reconfigured into Expert Panels as outlined in the Framework in Section 3, and

(f) 54 committees are retained. Of these 10 are Statutory Committees, four are Ministerial Committees, and 40 are Ministry of Health Committees (including 10 NSU and eight Ethics Committees).

5.3 FRAMEWORK FOR FUTURE COMMITTEE ESTABLISHMENT

The MRG recommends the following principles govern all committees, including Statutory, Ministerial Advisory, Ministry of Health, and NHB:

(a) Formal Ministry of Health Committees (Programme/Project Advisor Groups) should only be established on approval of the Senior Leadership Team,

(b) Programme/Project Advisory Committees may be established for the planning and initial implementation of a specific programme/project. However where ongoing advice from expertise not available within the Ministry of Health is required, existing networks should be utlised first to inform policy and programme development, especially for contentious or complex issues or those where sector support is required,

(c) All committees and Expert Panels should have a robust terms of reference, a workplan, and reporting requirements,

(d) All committees should have an independently appointed skilled Chair, whose role is not to represent an opinion but to ensure the committee fulfils its responsibilities,

(e) All committees and Expert Panels should consider how they include consumer voices in their processes,

(f) All committees and Expert Panels to use teleconference as the preferred method of meeting whenever possible,

(g) All committees to have an independent review of their terms of reference, delivery against the workplan, and membership to ensure they continue to add value and/or benefit to the sector, and

(h) All Ministry of Health committees to have an end-of-life date.

Committee structure. The following table outlines the recommended committee structure.

PHOs stratified by population size	Statutory Committees	Ministerial Advisory Committees	MoH and NHB Programme/ Project Advisory Groups	MoH and NHB Expert Panel
Rationale for existence	Established by an Act of Parliament	To provide advice to the Minster of Health on specific issues	The expertise required is not employed within the Ministry of Health; and/or Existing networks do not have the full required expertise; and/or There is a requirement for long-term expert advise	When expertise and input is required for a specific topic or piece of work Drawn from the service panel of experts (see below)
Term of office	Three years or less	Three years or less	One year or more	Short-term focused work then disbanded; or called together as required to fulfil a specific agenda
Renewal	As Minister of Health directs after the three-year review	As Minister of Health directs after the three-year review	As approved by the MoH Senior Leadership Team	

The MRG recommends that:

(a) That the above structure is endorsed for the future.

Terms of reference. As per the principles above all committees and Expert Panels will be required to have robust terms of reference that clearly outline:

- Purpose,
- Member skill base required,
- Member's responsibilities,
- Requirement to develop a work plan, including priorities and key milestones,
- Reporting requirements,
- Review process and date,
- Committee end date,
- Payment process, and
- Confidentiality requirements.

The MRG recommends that:

(a) That the Ministry of Health establish a common terms of reference template, and

(b) That the Ministry of Health develop a set of guidelines for the regulation and monitoring of committees and Expert Panels.

Full costs. In order to fully realise the cost of committees and Expert Panels to the health sector, the Ministry should reimburse members' employers (if work is undertaken as part of their employment for another entity but is not part of their work duties) or members themselves (if work is performed outside of any other employment contract) for their time. This payment needs to be adequate to reasonably reimburse members or their employers for the time spent in committee. Costs should include all actual costs of running a committee or Expert Panel, including travel and accommodation and FTE support costs. This would ensure the real cost of running of each committee and Expert Panel is transparent.

The MRG recommends that:

(a) That the Ministry of Health implement a full cost process for every committee and Expert Panel.

Panel of experts. In order to be able to access specialist advice easily and quickly the Ministry should develop a panel of experts approach for their networks. Calling for nominations from interested people to be part of a panel of experts would ensure access to expert advice when required. In this way the Ministry will develop a significant pool of expert advice they can call on rather than the current practice of establishing committees.

The MRG recommends that:

(a) That the Ministry of Health further develop the panel of experts approach to obtain advice from the sector.

5.4 ANALYSIS AND RECCOMENDATIONS FOR CURRENT COMMITTEES

5.4.1 Statutory Committees

There are currently 19 statutory committees most of which have not had their role reviewed in recent times. The recommendations made result mainly from internal Ministry of Health discussions. Any further amendments to the terms of reference and membership for the statutory committees will require further consultation with the Minister of Health.

The MRG recommends that:

(a) The National Health Committee be refocused with a broader mandate to advise the Minister on services that should be publically funded,

(b) The Public Health Advisory Committee be refocused with a broader mandate to advise the Minister on the configuration and provision of public health services,

(c) The National Health Epidemiology and Quality Assurance Advisory Committee, known as the Quality Improvement Committee (QIC), be replaced by an independent quality entity with responsibility for helping providers across the whole sector improve patient safety and service quality,

(d) The four Mortality Review Committees are merged into two committees,

(e) The Drinking Water Implementation Advisory Committee is not established,

(f) The Health Information Strategy Advisory Committee be disbanded and becomes part of the NHB IT capacity planning mechanism, and

(g) 10 Statutory Committees are retained, each to have a process established for three-yearly review of their terms of reference and membership to ensure they continue to add value and/or benefit for the Minister.

5.4.2 Ministerial Advisory Committees

There are currently six Ministerial Advisory Committees. One of these is time-limited and due to complete its work programme in December 2011.

The MRG recommends that:

(a) The Cancer Control Council of New Zealand be retained and the recommendations of the review of the terms of reference and membership are implemented,

(b) The Sanitary Works Technical Advisory Committee be retained and is refocused on the Drinking Water Assistance Programme only and meets once per annum,

(c) The Health of Older People Forum is disbanded in its current form, and

(d) The three other committees are retained, each to have a process established for three-yearly review of their terms of reference and membership to ensure they continue to add value and/or benefit for the Minister.

5.4.3 Ministry of Health Advisory Committees: Areas with numerous or high-cost committees

5.4.3.1 National Screening Unit Related Committees

The NSU 28 advisory committees cover a whole range of functions. The committees cost in the order of $428,000 per annum and utilise approximately 3.5 to 4 FTEs to service the committees. These committees all result from previous highly political situations, in particular cervical screening and breast cancer screening programmes. Changes to these committees therefore need to be carefully considered and managed. In May 2008 NSU undertook a review of all committees – the outcome of which will be implemented in the 2009/10 year. Overall the review has brought about a reduction in the number of committees, a reduction in the number of times the remaining committees will meet, and a refocusing of the committees' terms of reference to ensure they provide value to the programmes and increase their effectiveness. The result is a 44% reduction in committee cost, time and support, with an expected savings of $198,000 and 2.5 FTEs.

The MRG notes that 12 committees have already been reformulated into Expert Panels and recommends that:

(a) The NSU committees, including the Joint Ministries Committee and the Expert Panels, continue to be reviewed annually to ensure they are adding value to the NSU programmes.

5.4.3.2 Health Information Related Committees

There are currently 12 Health Information Related Committees. Of these six are standard-setting committees that will disband once their standard is approved and published by the HISO. One committee is due to disband in August 2009. Two committees have disbanded recently at the completion of their project.

The MRG recommends that:

(a) The National Systems Development Programme Sector Advisory Group and the National Systems Development Programme Connected Health Community Steering Group are disbanded, and

(b) The Health Information Standards Governance Group be disbanded and become part of the NHB IT capacity planning mechanism.

5.4.3.3 Training Related Committees

There are currently nine committees providing advice on training. One of these will disband in August 2008. It is recommended that six committees are disbanded and their functions become a standing feature of either the Nursing Reference Group or the Medical Reference Group in the Health Workforce Capacity and Planning capability of the NHB.

The MRG recommends that:

(a) Six of the current workforce committees' roles and functions become a standing feature of either the Nursing Reference Group or the Medical Reference Group in the health workforce capacity and planning capability of the NHB, and

(b) The Specification Review of Midwifery First Year of Practice Advisory Group and the Midwifery Post Graduate Education Expert Advisory Group be disbanded and their functions left to the Midwifery Registration Board.

5.4.3.4 Immunisation Related Committees

There were eight Immunisation Related Committees in the document. Three of these committees (related to the HPV programme) have already been disbanded as they have completed their work.

The MRG recommends that:

(a) The operational and committee functions of the National Influenza Strategy Group be separated and the structure and function of the committee be reviewed once 2009 influenza vaccination programmes are completed,

(b) An overarching Immunisation Technical Forum and an Immunisation Coverage Forum be formed to incorporate the current roles of the Immunisation Technical Working Group, the MenzB Effectiveness Group, and the Immunisation Programme Advisory Committee, and

(c) The need for one further committee (the National Immunisation Register Advisory Group) be reviewed as part of a review of the internal arrangements required to meet research, privacy, and ethical needs.

5.4.3.5 Communicable Disease Related Committees

There are currently eight committees related to communicable disease services, with one of these also relating to immunisation services (the Pneumococcal Surveillance Advisory Group). Two committees have already been disbanded and the MRG supports this.

Of the remaining six, the MRG recommends that:

(a) Five committees (the Hepatitis C Treatment Advisory Group, the AIDS Medical and Technical Advisory Committee, the Antibiotic Resistance Advisory Committee, the National Certification Committee for the Eradication of Polio and the Tuberculosis Advisory Group) be retained, and

(b) The terms of reference and membership of the Pneumococcal Surveillance Advisory Group be reviewed with a view to a broader role in vaccine preventable disease surveillance.

5.4.3.6 Ethics Related Committees

There are currently eight non-statutory Ethics Related Committees which consider 1,200 applications for Health and Disability Research each year. Where possible an expedited process is used where the Chair reviews applications and determines those that need full committee review. Committees have a maximum limit of 13 applications per meeting. In addition, the Ministry of Health recently established a web-based simplified review process aimed at streamlining the application process.

The Ministry of Health is currently undertaking a review of the Ethics System. The overriding drivers for the review are the public good component and the value for money component.

The MRG recommends that:

(a) Those recommendations from the review of the Ethics System pertaining to committee structure and role are implemented in a timely manner.

5.4.3.7 Cancer Related Committees

There are six Cancer Related Committees. Of these, one had already disbanded as it has completed its work programme and a further two are time-limited committees which will disband when their projects are complete. This leaves three core Cancer Control Programme Committees. Consideration was given to these committees' functions being undertaken by the National Health Committee; currently the skill base to do this does not sit within the NHC. In addition, implementing changes in cancer service delivery requires behavioural and cultural change and these remaining committees engage people who are leading the cancer sector.

The MRG recommends that:

(a) The three Core Cancer Control Committees are retained and reviewed annually to ensure they continue to add value to the Cancer Control Strategy.

5.4.4 Primary Health Care Related Committees

There are three Primary Health Care Related Committees. One is a timeframes committee due to be disbanded once the project deliverables are met. Another is the Primary Health Care Advisory Council (PHAC) which is a new committee established in August 2008. PHAC was implemented on 5 August 2008 and has a two-year term. Its purpose is to provide a forum for the Ministry of Health and DHBs to engage at a national level with leadership from across the primary health sector to ensure that the vision of the Primary Health Care Strategy is realised and that learning and experience gained to date informs the next phase of sector development. PHAC consists of members nominated from 15 primary health sector constituent groups. Members of the Council act as the mandated representatives of their constituent groups and it is expected that constituent stakeholders update and seek views on key decision items and ensure the mandate is firmly established. This is significantly different from the normal practice of appointing individuals to a committee. The fee for attendance is paid to the constituent group (excluding DHBs and the Ministry of Health) and it is up to them to decide how they remunerate the representative. Each group has a letter of agreement with the Ministry of Health which outlines their responsibilities and process for payment to the constituent group. The fee for each meeting is $1,200 per constituent group and is based on the normal daily rate the Ministry of Health would pay for policy advice.
The Council has a person appointed as the Chair whose role is to chair and ensure the issues are addressed in a timely manner. This committee fulfils many of the principles that the MRG recommends in the Future Framework. The committee is due for review at the end of its two-year term.

The MRG recommends that:

(a) Before the two-year term is complete the Primary Health Care Advisory Council have an independent review of their terms of reference, delivery against workplan, and membership to evaluate the value and/or benefit to the sector from the committee structure and process, and

(b) The functions of the Primary Health Care Nursing Expert Advisory Group be assumed by the Nursing Reference Group of the HWTB.

5.4.5 Ministry of Health Committees: Others

5.4.5.1 Finance Related Committees

There are four Finance Related Committees.

The MRG recommends that:

(a) The three common Finance Related Committees are disbanded and the functions move into the NHB role, and

(b) The National Capital Committee be disbanded and become part of the NHB capital capacity planning mechanism.

5.4.5.2 Maori Related Committees

There were three Maori Health Related Committees, two of which have already been disbanded.

The MRG recommends that:

(a) The Te Taumata Roopu – Maori Public Health Reference Group be retained and that its membership and terms of reference be reviewed annually to ensure it adds maximum value for public health services.

5.4.5.3 Nutrition Related Committees

There were four Nutrition Related Committees, one of which will be disbanded when its project is completed in December 2010.

Of the other three, the MRG recommends one is retained and that:

(a) The Food and Beverage Classification System Technical Advisory Group and the National Breastfeeding Committee are reconfigured as Expert Panels and called together as required for specific issues.

5.4.5.4 Tobacco Related Committees

There were five Tobacco Related Committees, two of which are run by the Health Sponsorship Council and not the Ministry of Health. A further two have been disbanded and the final committee will be disbanded when its project is completed in two years.

The MRG recommends that:

(a) The Ministry of Health work with the Cancer Control Council and the Health Sponsorship Council to remove any duplication of workplan, and

(b) The Ministry of Health reviews the requirement for the Tobacco Control Research Steering Group prior to the next contract being let.

5.4.5.5 Mental Health Related Committees

There are currently four Mental Health Related Committees. Three are time-limited service development projects and the fourth (Te Kokiri Advisory Group) meets twice yearly.

5.4.5.6 Diabetes and CVD Related Committees

There are currently three Diabetes and CVD Related Committees. One had just come to the end of its tenure and one will be disbanded when its tenure ends at the end of 2011.

The MRG recommends that:

(a) The National Diabetes Retinal Screening Advisory Group is disbanded.

5.4.5.7 Oral Health Related Committees

There are currently three Oral Health Related Committees, one of which has just completed its work. A second is to be disbanded when its work programme is complete.

The MRG recommends that:

(a) The third is currently retained.

5.4.5.8 Environmental Health Related Committees

There are currently three Environmental Health Related Committees.

The MRG recommends that:

(a) The workforce development component of the Health Protection Advisory Group is transferred to the NHB Health Workforce capacity planning function and that the committee meets up to twice yearly to fulfil its assessment process, and

(b) The Organochlorines Technical Advisory Group be disbanded and an Expert Panel be used as required.

5.4.5.9 Maternity Related Committees

There were two Maternity Related Committees, both of which have been disbanded.

5.4.5.10 Elective Service Related Committees

There are currently two Elective Service Related Committees.

The MRG recommends that:

(a) The Reducing Inequalities Expert Advisory Group be disbanded and that an Expert Panel be convened as required.

5.4.5.11 Youth Health Related Committees

There is one Youth Health Related Committee that is due to disband at the end of the 2009/10 year.

5.4.5.12 Disability Related Committee

There was one Disability Related Committee that has already been disbanded.

5.4.5.13 Well Child Related Committee

There is one Well Child Related Committee that the MRG recommends is retained.

5.4.5.14 Gambling Related Committees

There is one Gambling Related Committee.

The MRG recommends that:

(a) The Joint Ministry of Health/Department of Internal Affairs Stakeholder Reference Group on Preventing and Minimising Gambling Harm be reviewed and/or disbanded at the end of its term.

5.4.5.15 Health of Older People Related Committees

There is one Health of Older People Related Committees which is due to disband when the project implementation is complete.

5.4.5.16 Sexual Health Related Committees

There is one Sexual Health Related Committee which is currently in abeyance after reprioritisation by the Ministry of Health.

The MRG recommends that:

(a) The Sexual Health Advisory Group be disbanded.

5.4.5.17 Miscellaneous Committees

There were 11 miscellaneous committees, two of which have already been disbanded and one of which never commenced.

The MRG recommends that:

(a) Both the Nationwide Service Framework Co-ordinating Group and the Health Impact Assessment Support Unit Reference Group be reformulated into Expert Panels,

(b) The DHB Information Liaison Group be disbanded and the monitoring functions become the responsibility of the NHB, and

(c) The National Service and Technology Review (NSTR) Committee's role becomes a function of the reformulated National Health Committee.