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Is it finally time to reduce the number of district health boards?

New Zealand has 20 district health boards (DHBs) for a population of less than 5 million. Because of a lack of transparency, we do not know the costs of administering DHBs. But prima facie evidence suggests it is time to consolidate DHBs and free up administrative resources to use for additional services. In health care, size matters. Returns to scale and quality gains come with size. Optimising governance arrangements and the scale of services means more choice and improved health outcomes as pressures from ageing and public expectations intensify.

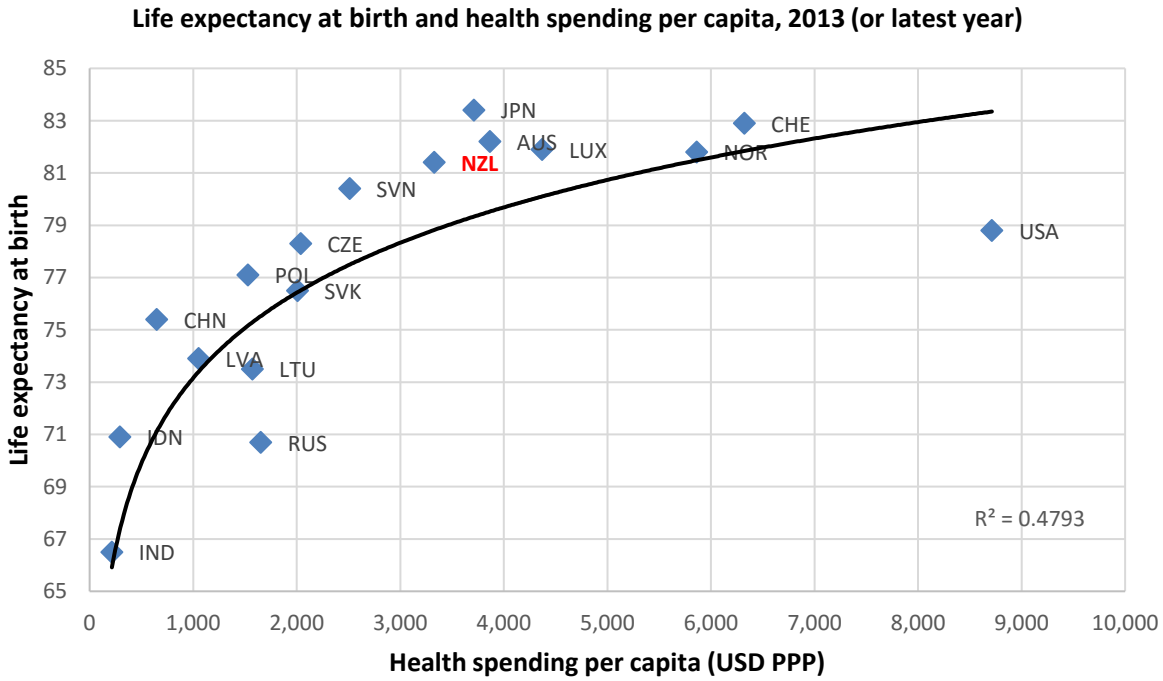
The health sector is performing well…

The 2016 Burden of Disease Study, *Health Loss in New Zealand 1990-2013* shows that the New Zealand health sector is performing well. Health is improving, but not all age and ethnic groups are doing well. New Zealanders increasingly will have complex health and disability needs. Transitioning to a health system that can respond to multiple-morbidity is a key challenge and will rely on coordination between different health disciplines.

At 9.5% of GDP (including ACC) New Zealand spends above the OECD average on health services – not as much as countries in Europe and North America, but more than Australia. All countries need to optimise expenditure on a constrained budget.

We compare favourably on system performance, with relatively high life expectancy on a modest budget but all systems are under pressure to provide more services and to do so efficiently.

International comparison of life expectancy and health spending



Source: OECD

...but there are demand side pressures

A February 2017 report from the New Zealand Treasury on DHB performance states that after several years of spending constraint, several DHBs are under pressure and having difficulty meeting financial targets.

Demand pressures will continue as the portion of the population aged 65 and over reaches nearly 25% by 2050.

New technologies and pharmaceuticals continue to expand; and with it expectations of access.

Some groups are missing out

The *New Zealand Health Survey* shows that more than 25% of the population have experienced unmet need for primary health care. People in low decile neighbourhoods report higher rates of unmet need. The Survey also reports rates of unfilled prescriptions at nearly 15%.

We also know that Māori and Pasifika have lower health status and report significant unmet need.[1]

Can DHB consolidation free up resources?

New Zealand has many DHBs. The governance and senior management teams have to offer a lot of value to their communities to justify their existence, especially in the smaller DHBs.

DHB populations in comparable jurisdictions

Jurisdiction	Pop (m)	DHB equivalents	Population per DHB
New Zealand	4.8	20	240,000
British Columbia	4.7	6	783,000
New South Wales	7.6	15	507,000

Source: National statistical agencies

This is because there are obvious trade-offs.

Unless decentralised administration clearly offers better value to a local community, a consolidated administrative approach has the potential to free resources for more local services.

The health care literature shows there are returns to scale and quality from critical mass and regular practice (see for example, Fareed's (2012) meta-analysis on the impact of hospital size on patient mortality). Several services are managed nationally or regionally (e.g. organ transplantation) to recognise this fact.

Where is the cost transparency?

Getting a clear sense of how much is spent on DHB administration is difficult. Administrative costs are not published in DHB annual reports.

The Auditor General in her *Reflections from our audits: Governance and accountability report of 2016* provides a set of observations as to the importance of public reporting. She notes that accountability enables trust in government and needs constant attention. This means residents can see how their taxes and rates have been used.

The information reported by DHBs needs to give a complete and accurate account of the use the entity has put public funds to, if DHBs are to meet the spirit of the Auditor General's observations.

Signs point towards consolidation

The public may be surprised that there are already four regional agencies[2] providing shared services with an additional layer of costs and governance. The combined budgets of these four shared services agencies exceed $200m.

Larger DHBs already provide substantial services to smaller DHBs. We see this in the volume of inter-district flows (patient flows i.e. patients from one DHB receiving care at another). 37% of Auckland DHB's revenue comes from other DHBs. In Wellington, nearly 20% of Capital and Coast DHB's revenue is from other DHBs.

These patient flows add a further administrative burden to the system because these transfers must be counted, costed and reimbursed each year. Small DHBs have to negotiate access.

Health Ministers have also appointed board members to more than one board. This serves to enhance coordination between DHBs and is a further signal that DHB transaction costs could be reduced through consolidation.

How valid is the claim that DHBs are about democracy and local autonomy?

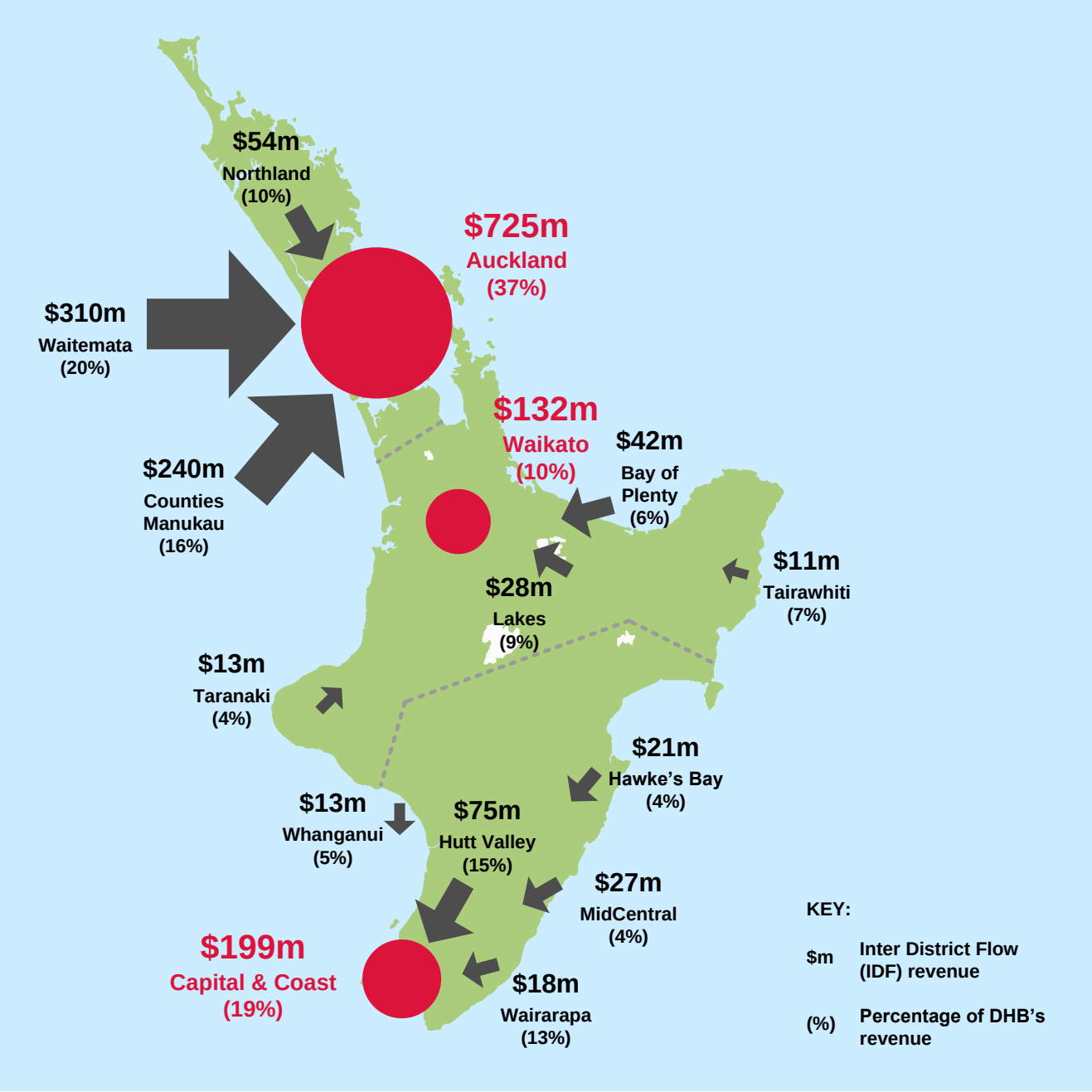
Voter turnout in DHB elections was 41% at the 2013 election.

Turnout ranged from 34% to 55% in 2013 with smaller DHBs recording higher turnout.

[1] See Ministry of Health reports from 2013.

[2] Northern Regional Alliance (Upper North Island), Health Share (mid North Island), Central TAS (Lower North Island) and the South Island Alliance.

Patient flows in the North Island



Source: NZIER based on Ministry of Health

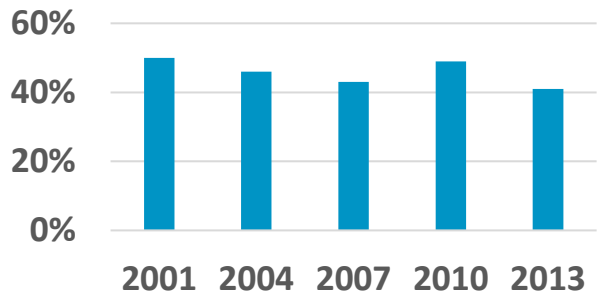
DHBs are only partially elected with room for four ministerial appointees alongside the seven elected members. This makes for 220 'governors' across the DHBs.

The 2015 *New Zealand Health System Independent Capability and Capacity Review* noted that DHB governance and leadership competence appears to be "lacking in practical day-to-day execution". The Review recommended a reduction in the size of the boards.

Health services are complex but DHBs have very sizeable funding, reporting and service change approval requirements to the Minister and Health Ministry. Funding is from the centre and not locally raised so financial accountability is straight back to Wellington as the source of funds. Local district health board discretion to alter or change the service mix is limited. Any significant changes require consultation and approval with Ministers. On matters of national infrastructure (i.e. ICT), negotiations are often required with each of the 20 DHBs. As new digital

treatment technologies emerge (e.g. in-home screening) the need for local discretion is non-existent or very limited because a nation-wide system has to be able to talk to itself to offer consistent and coordinated service.

Voter turnout in DHB elections



Source: Department of Internal Affairs

What next?

DHB and shared service agency administrative costs need to be collected and reported in order to meet the spirit of the Auditor-General's reflections on good public reporting.

Transparent costs are needed so the local governance costs, local administration costs, patient flow management costs, and regional coordination costs can be contrasted with the potential to free resources for additional services and to reap the returns to scale and quality.

This is especially important when we have under-served populations that report access barriers to primary care.

If consolidation of DHBs frees up resources for more services, then we think it's worth a closer look.

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