

The screenshot shows a web browser window with the URL <http://beehive.govt.nz/feature/sector-changes-and-disability-support-services-funding-options-2>. The page header includes the beehive.govt.nz logo and navigation links. The main content area displays a memorandum by Annette King, Minister of Health, dated 1 August 2000. The title of the memorandum is 'Sector Changes and Disability Support Services Funding Options /2'. The content is a proposal regarding District Health Boards (DHBs) and funding for disability support services (DSS).

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**Annette King**

**1 AUGUST, 2000**

## **Sector Changes and Disability Support Services Funding Options /2**

**HON ANNETTE KING, MINISTER OF HEALTH**

Memorandum to Cabinet Social Policy and Health Committee

**Sector Changes and Disability Support Services Funding Options**

**PROPOSAL**

1. It is proposed that:
  - i. District Health Boards (DHBs) should ultimately be responsible for funding disability support services (DSS) when deemed capable, except for those services determined by Government following scrutiny of the Establishment Plans
  - ii. further governance and accountability measures are added to strengthen the identity for disability support issues.

### **EXECUTIVE SUMMARY**

2. This report considers options where funding for disability support services is distributed to providers by:
  - i. DHBs, individually or in collaborative arrangements, with few exceptions

- ii. the Ministry of Health (or another central agency)
  - iii. alternative district-based organisations - either existing or new structures
  - iv. a mixed approach, where DHBs fund DSS that require high and local co-ordination with health services (i. above), and one of the alternative funding arrangements in ii. or iii. above for other DSS.
3. The key issue is that the basis of health and disability support service provision is not the same. For some groups of people with disabilities a close association with health services is not relevant, and can limit the development of a distinct identity and philosophy for disability support services. Funding options are assessed on the extent to which they contribute to a clear identity for disability support issues, while ensuring accountable and effective use of public funds.
  4. There are some good arguments for separately funding DSS that have a weak link to health services. In practice, however, it is difficult to establish a good working definition to do so. Grey areas would make coordination with providers more difficult, and create confusion about who is accountable for which services so that people may fall through cracks. Such issues would be manageable if the Ministry of Health were responsible for administering the separate funding, instead of separate organisations. But the Ministry would incur additional administration costs to maintain relationships with, and monitor, local providers. A large funding role would also create tension with its policy and monitoring roles.
  5. There are no existing local agencies with capability to separately administer all or part of DSS funding. The creation of new local structures is very costly. This may, however, be a longer-term option following implementation of the New Zealand Disability Strategy and development of the disability sector.
  6. Officials recommend that DHBs administer funding for most DSS, once DHBs can demonstrate to Ministers that they have the appropriate capability and culture. There would be provision for some funding to be administered by the Ministry. These exceptions could include DSS with a weak link to health services, and will be determined by the Government following consideration of DHB transition plans and as the NZ Disability Strategy develops.
  7. This mixed option provides Ministers with the widest range of levers to pursue Government's objectives for the disability sector, particularly if combined with a range of additional governance and accountability measures to emphasise a clear identity for disability support issues. The option reflects the broad focus that DHBs will be expected to have in 'delivering' for their local populations, and builds on existing capability, networks, and policies (including, Needs Assessment and Service Coordination Agencies some of which are located within HHSs). Many of the benefits will be achieved through promoting a culture of collaboration among providers and with funding agencies. Compared to the alternatives, this is the most effective option in addressing service co-ordination issues, administration costs, and fiscal and implementation risks.

## **BACKGROUND INFORMATION**

### **Objectives for Supporting People with Disabilities**

1. The Government's overarching aim for the disability sector is to empower people with disabilities to overcome the barriers to participation in their communities and the achievement of their full potential as individuals. Disability issues are being given a separate identity, as reflected in:
  - i. a separate Ministerial portfolio for Disability Issues

- ii. a Disability Issues Directorate within the Ministry of Health led by a Deputy Director-General
- iii. the development of a New Zealand Disability Strategy to guide policy and service development, and its inclusion in the New Zealand Public Health and Disability Bill.

### **Disability Support Services**

2. Disability support services are those services for people with disabilities which are currently funded by the HFA. Other government departments and agencies, such as the Ministry of Education, the Department of Work and Income and ACC also have responsibility to provide services to meet the support needs of people with disabilities. DSS funding is administered through the DSS Framework, which consists of three distinct processes (see Table 1).

### **Sector Changes**

10. Cabinet has previously decided that DHBs will be accountable for funding or providing the mix of services which ensures the best health and independence outcomes for their populations within available funding [Cab (00) M11/1A].
11. The Ad Hoc Ministerial Committee on Health Sector Change agreed that DHBs should have responsibility for planning and funding all health and disability services, with the exception of those determined by the Government. The detailed scope and timing of devolving responsibilities will be determined by Ministers following assessments of DHB transition plans in November 2000.
12. Ministers have sought further, broader advice on funding options for DSS. Options canvassed in this paper may have implications for the introduction of the New Zealand Public Health and Disability Bill and the implementation of sector change. These risks are identified.

### **ISSUES FOR DSS**

13. Concerns have been raised by parts of the disability sector that DHBs would not be an appropriate funding agency for DSS because such services are not health services and DHBs will not adequately address disability support issues.
14. Particular concerns that have been expressed are that:
  - i. health and disability support services require different approaches to rationing and different relationships between funders, providers and people receiving services (that is, people with disabilities have different kinds of needs over different timeframes)
  - ii. disability issues will not have a clear identity within DHBs, as:
    - a. DHBs are being built from HHSs so that DHBs may be too focused on medical treatment related services, particularly hospital based care
    - b. there is no guaranteed DSS perspective on DHB boards, or its subcommittees, so that DHBs may not understand, or have much sympathy for, DSS issues or philosophy
  - iii. it will be harder to achieve consistency in access to, and quality of, DSS delivery and to further nationwide initiatives
  - iv. funding from DSS will be diverted to health services
  - v. scarce disability service planning and funding expertise will be diluted if spread among 22 DHBs
  - vi. some regional and national non-government DSS provider organisations may have to enter into complex agreements with many DHBs.
15. These concerns support arguments for separate administration of DSS funding. However, they do not fully recognise the broader functions and culture that DHBs

will be required to have. DHBs will be required to focus on the broader determinants of health and independence, recognising the importance of linkages with other social services (such as housing, transport, income support, education, employment, as well as vocational and child protection services). Such linkages are particularly important in removing the barriers to independence and participation.

16. In relation to support services for older people, there is a view that the focus within DSS on removing environmental barriers to participation and independence has led to a system which does not adequately address the needs of people who require ongoing medical intervention as well as long-term care and support services. The National Health Committee, in its report Health Care for Older People, recommends that future funding arrangements for older people's services should encourage integration between primary, secondary, DSS and public health. Age related disability support services comprise 51 percent of the DSS budget. The NHC's recommendations may be viewed as favouring integration of health and DSS funding for elderly people.
17. There is also a complex interface between DSS and mental health for people with a psychiatric disability or dual psychiatric condition and disability (particularly intellectual disability or deafness). Given the need for coordination between treatment for acute episodes and long-term care and support for people with mental illness, it would be more appropriate that funding for psychiatric disability is integrated with funding for mental health. Psychiatric disability services comprise 20 percent of the DSS budget. Funding allocation issues form part of advice to the Ad Hoc Committee due at the end of June.
18. This means that about 70% of DSS funding goes to people with disabilities who require intensive health care on an ongoing or intermittent basis.
19. Despite the issues identified, services do work well in a number of instances. This suggests that a change in culture (led by the New Zealand Disability Strategy and New Zealand Health Strategy, and supported by performance accountabilities and monitoring) will be as important as organisational structures and funding streams.

#### **CRITERIA FOR ASSESSING FUNDING OPTIONS**

20. Criteria used to assess funding options are:
  - i. a clear focus on disability support issues
  - ii. clear accountability
  - iii. management of fiscal risk
  - iv. management of service risks
  - v. coordination of services (promoting the best 'fit' between DSS planning and funding mechanisms and those for health and other social services)
  - vi. responsiveness to the needs and preferences of people with disabilities and their families/whanau
  - vii. minimising administration costs
  - viii. implementable within a reasonable timeframe
  - ix. limited disruption to the sector.
21. Appendix 1 contains an evaluation of the main options against these criteria.

#### **FUNDING OPTIONS**

22. The four options are where DSS funding is distributed to providers by:

- i. DHBs, individually or in collaborative arrangements, with few exceptions
- ii. the Ministry of Health (or another central agency)
- iii. alternative district-based organisations - either existing or new structures
- iv. a mixed approach, where DHBs fund DSS that require high and local co-ordination with health services (option 1. above), and one of the alternative funding arrangements in ii. or iii. above for other DSS.

### **Option 1: fund DSS through DHBs**

#### *How it could work*

1. Under this option, District Health Boards would be funded to assess the disability support needs and arrange provision of the full range of disability support services for their populations (Figure One). There would be collaborative DHB arrangements for funding national organisations (such as possibly Equipment Management Services) or shared frameworks (such as standard base contracts) to reduce the administration cost of national service providers having to negotiate with 22 DHBs. It may be that some funding is administered directly by the Ministry of Health, where Government has determined that there are no suitable DHB arrangements.
2. The DHBs would be working in an environment with the following governance and accountability mechanisms, aimed at ensuring an appropriate focus on DSS:
  - i. the New Zealand Disability Strategy - to articulate priorities and expectations
  - ii. requiring DHBs to work within national service specifications, guidelines, protocols, targets and bench-marked performance standards, to be consistent with the DSS framework and the New Zealand Disability Strategy
  - iii. funding agreements to set performance accountabilities for disability support services
  - iv. monitoring and reporting on DHB performance
  - v. Ministerial appointments to DHB boards - to fill key skill and knowledge gaps, such as disability issues.
3. DHBs could also use needs assessment and service co-ordination agencies (NASCs) to get DSS advice on service needs and delivery. NASCs are a key component of the DSS Framework and the main access point for DSS. A number of NASCs are located within or owned by HHSs, so that NASCs would be transferred to DHBs, alongside with other HHS assets. NASCs have ties with local people with disabilities and service knowledge.
4. The Ministry of Health would play a strong role developing frameworks, assisting with developing standard contracts, and facilitating and working with DHBs to plan for DSS services. A crucial role would be the Ministry's support in developing DHB accountabilities and the monitoring of performance against expectations. The Ministry would not, however, need to fund disability services directly in order to ensure these ends, although it could do so when DHBs have not yet developed the capacity.

#### *Advantages and disadvantages*

5. The advantages of this approach are that DHBs would be clearly accountable for improving both the health and the independence of a given population. As DSS funding would remain with health funding, it facilitates coordination of planning and delivery of health care and DSS services. This is particularly important for the frail elderly, people with complex disabilities requiring

regular medical interventions and people with degenerative medical conditions. Close coordination between health and disability support services (for example, support following discharge from hospital, or referral) is important for the bulk of DSS spending and has greater chance of occurring if funding for DSS and health services are administered by the same agency. Currently, demand for older people's health and disability support services is growing more rapidly than for other disability groups. Retaining a single funder for both health and DSS provides greater opportunities for developing integrated service packages than when there are separate funders.

6. The main disadvantage is that this may not appear to address the concerns amongst the disability groups about 'health capture' of disability issues, or fully recognise that disability support services and health services are different. The transition from HHSs to DHBs would need to be accompanied by a significant change in culture to give confidence that DHBs would meet the challenges of working across differing philosophies and expectations.

#### *Additional measures to address concerns*

7. In addition to the provisions already made, there are further options for governance and accountability arrangements to address concerns:
  - i. retaining a DSS ringfence or other ways of protecting DSS funds (to be considered as part of the report-back to the Ad Hoc Ministerial Committee on Sector Change, due 30 June 2000)
  - ii. renaming the DHBs as District Health and Disability Boards, to reinforce DHBs' statutory responsibility for disability support issues
  - iii. establishing a Disability Support Advisory Committee in each DHB.
8. Decisions to date do not require DHBs to set up a committee to advise specifically on disability issues. These issues would at least have to be considered by the Health Improvement Advisory Committee when providing advice on relative local priorities among health or disability services. Boards can, however, set up any committee.
9. The Minister of Health can encourage or require boards to set up disability support advisory committees (see figure two). But for some, particularly smaller, DHBs, it may not be the best use of funds to set up additional committees. As DHBs will have considerable freedom as to the size and make-up of advisory committees, this does not seem to be an overly onerous requirement. There is a risk that there be insufficient linkages between the sub-committees, but high-performing boards will be capable of making the required linkages.

#### Figure two: DHB subcommittees

10. We recommend that, if DHBs are to fund most disability support services, the Bill require DHBs to set up a disability support advisory committee to provide advice on the disability support needs of the population and priorities for using available disability support funding. This can be relatively easily inserted in the Bill as the provisions would be similar to those that apply to the health improvement advisory committee.

### **Option 2: funding through the Ministry of Health or another central agency**

#### *How it could work*

1. Disability support could also be funded separately in its entirety by the Ministry of Health. Under this approach, both planning and funding for disability support services would be separated from health services which will

ultimately be funded largely through DHBs. If the Ministry of Health is to be responsible for funding and monitoring DSS providers, it would need to establish good local links with providers and DHBs. This would mean, in practice, a local presence around the country.

2. It would also be possible to use another central agency. It is assumed that creation of another central agency in the health sector is inconsistent with Government policy. Candidates, therefore, could be the Department of Work and Income (given historical links and its local presence) or a new department for disability issues. These options are also assumed to be currently outside the scope of feasible options. If Ministers indicate an interest in using another department, then this would require further development. This would have significant implications for legislation and implementation.

*Advantages and disadvantages*

3. The advantage of separate central funding would be that it could give disability support a stronger identity at the central agency level. With a much closer and detailed involvement in how the funding is spent, it could strengthen efforts to achieve a nation-wide consistent philosophy for, and approach to, DSS. It could save some costs by combining planning and funding expertise and central administration of contracts. Separate central funding would also protect DSS funds from being diverted to health services. However, many of these aspects could also be secured through using DHB accountability mechanisms.
4. A major disadvantage of separate central funding is that it could confuse who is accountable for the health and independence of local populations. Past experience shows that this gives different agencies scope to cost-shift. It would also inhibit local decision-making on the local direction of disability support services, and their priorities, which is one of Government's key policy objectives. It would disadvantage smaller local organisations (including Maori providers) and inhibit local innovation, as national funding agreements can make it harder for local organisations to gain contracts, even if these services may be better for the client and/or more cost effective. There are also additional administration costs if the Ministry of Health funds DSS separately, as there would need to be either local offices or travel to localities to set up service agreements and to monitor provider performance.
5. A further concern is that central DSS funding would inhibit co-ordination with local health services. This could result in barriers and delays in movement between health and disability support services. This would be of particular concern to the frail elderly, people with complex disabilities requiring regular medical interventions and people with degenerative medical conditions. Close co-ordination and the monitoring of providers' performance can be better achieved at a local level rather than nationally.