

Meeting the Challenge:

Enhancing Sustainability and the Patient and
Consumer Experience within the Current Legislative
Framework for Health and Disability Services
in New Zealand

Report of the Ministerial Review Group

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Executive Summary

It is important that New Zealanders continue to have affordable access to a strong public health and disability system which provides world class quality care, both now and in the future.

However, the sustainability of our public health and disability system is under serious threat.

- We have an ageing population with more long-term health problems which will require greater health care in the future, with the growing burden of paying for that health care falling on a relatively smaller number of workers and taxpayers.
- We have real issues around our health workforce, which has a high dependence on overseas born and trained staff in a world of growing health workforce shortages, and with our ability to pay internationally competitive salaries falling behind faster growing economies.
- Some hospital services in some regions are already vulnerable to staff shortages and six smaller DHBs are likely to become more vulnerable as their workforce ages and their populations shrink.
- We have mixed health indicators when compared to other OECD countries, and public concerns about waiting times and volumes of elective surgery.
- There are issues around the quality of care with the Health and Disability Commissioner often citing cases where potentially preventable errors have occurred.
- We want a public health and disability system of the same standard as other OECD countries yet we do not earn like those countries, so our system needs to be made more effective and productive than the OECD average to bridge that gap.
- The public system still struggles to sustain itself financially, despite the substantial increase in funding it has received over recent years. DHBs are running deficits of about \$150 million for the 2008/09 year and have \$436 to \$636 million unfunded capital requests for the 2009 year.
- The cost of providing public health and disability services is increasing year-by-year, at a rate far greater than growth in our GDP, and will continue to take an even larger share of our national income unless we change the way these services are provided.

The MRG has undertaken a frank and often unsettling review of the challenges we face and has developed recommendations to help meet these challenges. The recommendations are based around one central theme – ensuring that New Zealanders continue to be well served by a world class health and disability system.

To achieve this we must find a way to deliver these public services within a more sustainable and, therefore, slower path for health expenditure growth. This simply means that as a country we do not have the resources to continue spending increasing amounts on the public health and disability system at the rate at which we have.

That means that our public health and disability system must operate more efficiently. Bureaucracy, waste, and inefficiencies must be reduced and resources moved to the front-line as spending growth slows. We must focus on quality which will deliver better patient outcomes and on ensuring better access to health services through smarter planning and resource utilisation, at regional and national levels.

The Report's recommendations are presented around nine key themes:

- New models of care which see the patient rather than the institution at the centre of service delivery and which aim to promote a more seamless patient journey across community, primary, and hospital sectors, greater use of primary and community care, and the shifting of care 'closer to home',
- Stronger clinical and management partnerships to ensure that doctors, nurses, and other health professionals play a key role in decision-making,
- A sharper focus on patient safety and quality of care to ensure better results for patients and more services for the resources we have available,
- Identifying the services people need to bring a more measured, safer and more nationally uniform approach to the introduction of new medical technology and new clinical procedures,
- Putting the right services in the right place by ensuring that the sector is configured – nationally, regionally, and locally – to best meet the needs of New Zealanders,
- Ensuring the right capacity is in place for the future by improving structures and processes for workforce, capital, and IT planning and funding,
- Building a sustainable workforce to ensure that we have planned and developed a workforce that meets our future needs,
- Shifting resources to the front-line by reducing the cost of 'back office' shared services for DHBs and reducing the duplication of functions carried out across the country, and
- Improving hospital productivity by reducing the variation in clinical and financial performance within and between hospitals, so they can do more with the resources available to them.

The Group's recommendations are of two broad types:

- Those aimed at encouraging changes in culture and processes to, for example, promote greater clinical leadership and engagement in decision-making, and improve the integration of primary and hospital-based care, and
- Those recommending changes in structure and aimed at: reducing waste and bureaucracy; improving safety and quality; and enhancing clinical and financial viability.

We have tried to keep structural change to the minimum required to meet the challenges we face within the current legislative framework.

The main structural changes the MRG are recommending are:

- Transferring the planning and funding of those services that are truly national services from DHBs and the Ministry of Health to the Crown Health Funding Agency (which we propose be revamped into an organisation provisionally called the National Health Board (NHB)). Shifting the monitoring of DHBs from the Ministry to the NHB, so that the latter has a complete view of health service planning and funding,
- Bringing together the various activities associated with strategic planning and funding future capacity (IT, facilities and workforce) at the national level and transferring them into the NHB, so they can be better integrated and driven by future service requirements,
- Requiring DHBs to plan on a regional basis, and establish the governance and support arrangements to deliver those plans,
- Creating a new Crown Entity to provide shared services to DHBs and reduce the cost of common 'back office' functions so that more resources can be shifted to the front-line. Some of the national operations currently managed by the Ministry on behalf of the sector would also be transferred into this entity,
- Asking the Ministry of Health to review all of the \$2.5 billion in funding that it still manages, over the coming year to identify what would be better devolved to DHBs for management at a regional and local level, and what should be managed nationally by the NHB and advise the Government accordingly,
- Revamping and strengthening the National Health Committee, so that it is better able to perform its original role of assessing the appropriateness and cost-effectiveness of new services, and progressively reassessing existing services,
- Strengthening national leadership on safety and quality by replacing the Quality Improvement Committee (QIC) with an independent national quality agency, and
- Reducing the number of health committees from the original 157 identified six months ago to a list of 54 that should be retained under the new structure.

The above changes will lead to reduced bureaucracy and a smaller Ministry of Health over time, with a much clearer focus on the Ministry's core policy and regulatory functions. The NHB will also bring a clearer focus to service and capacity planning and funding. These proposals will also require some changes by DHBs, albeit aimed at accelerating their current moves towards greater collaboration regionally on service planning and nationally on reducing common back office costs.

1 Introduction

- 1 At the heart of this report is a desire to ensure that our public health and disability system is better placed to meet the many challenges it faces. As New Zealanders we need to be confident of receiving high quality health care and disability support we can afford.
- 2 While this report has a heavy emphasis on improving the nuts and bolts – the culture, structures, systems, and processes that need to be addressed to ensure the public health and disability system remains sustainable – it should be remembered that its real focus is on providing for the health and well being of New Zealanders.
- 3 Despite many years of very strong spending growth, the public health and disability system still struggles to sustain itself, a task that will become even harder in the future.
- 4 Unless we change the way services are provided, it will become increasingly difficult to meet public expectations for improved service within a sustainable funding growth path.
- 5 The current service delivery model is driven by the decisions of the Ministry of Health and 21 separate District Health Boards (DHBs). The Ministry of Health acts as the primary policy advisor and performance monitor, as a regulator, as a funder of health and disability services and as a manager of national operations. The DHBs act as funders of services for their district population and as providers of health and disability services.
- 6 While the Ministry of Health is well served by its people, it is being asked to do too much across too diverse a spectrum of activity.
- 7 The report recommends that the Ministry focus more on its core policy and regulatory role and gradually shift its non-core functions elsewhere. It should review the 20% of the health budget it still holds over the next year and either devolve it to DHBs or, if the services it is funding are truly national in scope, transfer them to the Crown Health Funding Agency (CHFA) which will be revamped into an organisation provisionally known as the National Health Board (NHB). We are proposing that this agency be responsible for planning, and funding national health services, monitoring DHB's performance, and planning and funding capacity investments (capital and IT investments and workforce training and development issues, currently managed by the Ministry). We are also proposing the creation of a new Crown Entity to act as a shared service provider to the DHBs, to bring together much of their back room functions, and assume the responsibility for some of the national operations functions currently carried out by the Ministry.
- 8 The recommendations put forward in this report are designed to ensure that there is minimal disruption within the wider health and disability sector, with changes focusing on regional planning and shared services. The changes however do spell short-term widespread change to the Ministry of Health, as functions are transferred to the NHB or devolved to DHBs or the new National Shared Service Agency. These changes will bring greater clarity to the Ministry's role to assist it to focus on Government priorities.

9 The changes being recommended will result in reduced bureaucracy as: the myriad of national programmes are prioritised, unified and simplified: roles and accountabilities are clarified; and the number of committees reduced.

- 10 The current framework has a number of serious flaws such as: the duplication involved in DHBs doing similar things 21 times; the difficulty in coordinating service delivery at the regional and national level; and an inability to make investment decisions based on a long-term view of improved national service configuration or models of care.
- 11 Attempts to address these flaws by DHBs¹ from the 'bottom up' have been slow and uneven because the local interests of 21 individual DHBs often take priority over any regional or national planning.
- 12 Attempts by the Ministry of Health to manage this system 'top down,' in order to ensure rapid implementation of the Government's national priorities, have been seen to cut across DHB autonomy and differing local needs as well as imposing excessive bureaucracy and administrative overheads. Funding for new national initiatives also tends to be 'layered' on top of existing DHB activity, rather than requiring DHBs to reprioritise.
- 13 There is a widespread sense of frustration amongst those wanting to make progress on these issues, both locally and nationally.
- 14 The view of this Ministerial Review Group (MRG) is that there are "missing links" in the current arrangements that need to be created in order to give the existing framework, based on 21 DHBs and 82 PHOs, a better chance of future success.
- 15 The few structural changes affecting DHBs that we are suggesting aim to accelerate and lock-in the slow and uneven evolution that is already occurring in the system.
- 16 They aim to reduce the waste in doing similar back office functions 21 different ways so that more resources can be shifted to the front-line.
- 17 They also provide a framework for regional and national planning and funding, and nationally coherent investment and workforce decisions, that can improve utilisation of existing capacity and ensure a better mix of new capacity in the right places.
- 18 The suggested arrangements still recognise local needs but are not hostage to parochial interests.
- 19 It is also essential to strengthen clinical leadership and the role of doctors, nurses allied and other health workers in decision-making. This needs to be done in a way that recognises that both clinicians and managers have to share responsibility and accountability for improved system performance, in terms of efficiency, quality, and cost.

¹ The Health and Disability Act 2000 makes it clear that "the Crown and DHBs must endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services" (Section 3 (5)). It also requires a majority (seven of the up to 11) of the DHB Board members to be elected in order to "provide a community voice."

- 20 We are also making recommendations aimed at clarifying and strengthening the role that primary and community care can play in better integrating primary and hospital services and delivering care 'closer to home'. We are suggesting a much stronger focus on improving patient safety and service quality, an area where we should be able to simultaneously improve health outcomes and reduce cost and cost growth.
- 21 Additionally, we are also proposing expanding the role of Pharmac and strengthening the role of the National Health Committee (NHC) in order to bring a more deliberate, measured, and safer approach to the adoption of new medical technology and new clinical procedures.
- 22 Taken together, these changes give us a real opportunity to reconfigure service delivery and change models of care over time to better meet the challenges ahead.
- 23 These recommendations will help accelerate key aspects of the Government's health policy and help achieve their vision of a public health and disability service: that is more patient-than provider-centric, giving patients more supported self-care, and helping them make informed choices; produces more integrated care and a seamless 'patient journey' through the system; and moves care as close to home as possible.
- 24 While our recommendations will make the current framework work better, we are not able to say if they will be sufficient to meet the huge challenges in front of us.
- 25 We have been struck by the lack of support for maintaining 21 separate DHBs, for example, and the number of people who believe that some rationalisation is required.
- 26 Working within the current legislative framework allows much earlier action in meeting these challenges and avoids the risk of more substantive and disruptive change that may not prove necessary. On the other hand, this approach runs the risk of not going far enough fast enough. We have also therefore recommended that the results of these recommendations be reviewed within three years to determine if they are successful enough in lifting sector performance within a slower funding growth path.

2 Scope and structure of this report

27 This report has been prepared by the MRG in response to its terms of reference (attached as Annex 7):

- To improve performance and quality,
- To improve the system's capacity to deliver into the future, and
- To move resources to support front-line care.

28 The detailed issue-by-issue responses to each point in the three sections of the terms of reference are attached as Annex 2, 3, and 4 respectively. Annex 5 is a fuller discussion of the issues surrounding encouraging greater clinical engagement and leadership. Annex 6 provides a comprehensive list of our recommendations.

29 The purpose of this covering report is to bring together and highlight the key themes from the Annexes in a way which illustrates how they combine to help secure the clinical and financial sustainability of our public health and disability system and improve people's experience of it.

30 We have organised our report around these two themes because they best reflect our terms of reference and because the mounting challenges we face mean that we need to take action on these issues now.

31 We also wanted to demonstrate that there was much we could do to secure financial sustainability and improve service quality and safety at the same time.

32 This does not mean that the MRG considers other objectives less important, like reducing inequalities, improving independence, or enhancing peoples' sense of security that they will have the quality health and disability services they need without facing substantial financial costs in accessing them. Indeed, being able to make progress on these other objectives is crucially dependent on ensuring that the system we have is able to meet the very significant challenges facing it.

The Challenge

3 Today's challenge

3.1 HEALTH SPENDING AS A PERCENTAGE OF GDP

33 New Zealand spends a high proportion of its national income on health. It is higher than the OECD average and – with the exception of the US, Switzerland, France, and Germany – it is not materially different from the highest in world. This is the direct result of New Zealand's relatively poor income growth, rather than of relatively high health spending. We spend less on health per capita than the OECD average and still enjoy relatively good health outcomes in many areas, such as life expectancy. The difficulty is that our per capita income is much weaker than this per capita health spend. We like to consume health services like other OECD countries but we are less able to afford to.

34 Spending on health has also been growing much faster in New Zealand than it has in other countries, especially when compared with income growth. Since 1995, growth in health spending has exceeded growth in national income by 30% in New Zealand versus an OECD average of 18%. The rate of health spending growth was around 10% per annum over 2002-08, although this has slowed recently as has GDP growth.² Given likely rates of nominal GDP growth in the 4-5% per annum range, maintaining this rate of growth in annual health spending would require us to devote an ever larger proportion of national income to health and an ever smaller amount to everything else. Clearly, this is not sustainable longer term.

3.2 PATIENT SAFETY AND QUALITY

35 Models of care have remained largely unchanged while the challenges facing health services have changed significantly. The complexity and chronic nature of much of the current-day health burden requires a greater emphasis on team work and continuity of care across community, primary, and secondary care settings. Quality of care issues in recent Health and Disability Commissioner cases highlight problems with fragmented care, for example resulting from poor patient handover between different providers and sometimes even within the same institution. The Health and Disability Commissioner has highlighted the need for more progress on improving patient safety and service quality.³

We like to consume health services like other OECD countries but we are less able to afford to

² Treasury CFIS net data, growth in Vote Health of 10.6% per annum, gst exclusive, and excludes capital expenditure and based on functional years.

³ In both the HDC *Annual Reports* and in his comments to the Health Committee's 2006/07 *Financial Review of the Health and Disability Commissioner*. In the latter, for example, he said, "I think we are still making slow and patchy progress on patient safety. Back in our annual report in 2006 I said it was slow, patchy, and uncoordinated. In that same year, two of our leading quality experts, Professor Alan Merry and physician Mary Seddon, said that our hospitals were not acceptably safe at present, and that remains true."

3.3 UNEVEN SERVICE IMPROVEMENTS

36 Service improvements have also been uneven, despite recent growth in health spending. While there are some signs that health inequalities are improving, there is still a long way to go, despite significantly reduced patient co-payments. Waiting times and access to surgery are still a major public concern, especially for assessments, electives, cancer treatments and within emergency departments of public hospitals. Health outcome and quality indicators are quite mixed compared to other OECD countries, with New Zealand doing relatively well on some indicators and poorly on others. There is still a long way to go to deliver the Government's vision of a public health and disability service that: is more patient- than provider-centric, giving patients more control and helping them make informed choices; produces more integrated care and a seamless 'patient journey' through the system; and moves care as close to home as possible.

3.4 VULNERABILITIES

37 New Zealand's health system also faces financial and staffing vulnerabilities despite big budget and wage increases. DHBs are finding it very difficult to operate a truly 'break-even' operating model, let alone provide for anticipated asset replacement or upgrading. Although the number of senior medical staff has increased by 46% over the past 10 years,⁴ many of our tertiary and secondary services are still vulnerable to staff shortages and some are hard to staff on a permanent basis, especially in smaller centres. Perhaps our greatest vulnerability is our reliance on an internationally mobile professional workforce in a world of growing health workforce shortages. For example, more than half of the doctors working in New Zealand and more than 40% of our medical specialists were born overseas.⁵ The training and retention of a New Zealand trained workforce is a major issue, both in terms of numbers as well as distribution across the country. The development of a different type of workforce with greater flexibility in scope of practice has not really eventuated. We need to strengthen the link between current training programmes and the skills the sector needs now and in the future, and would agree with the SMO Commission that national demonstration projects are needed to support more widespread innovation in workforce models.⁶ There has also been a lack of progress in industrial relations. Moving forward, industrial relations need to be less adversarial and support change in models of care and more flexible workforce development.

Perhaps our greatest vulnerability is our reliance on an internationally mobile professional workforce in a world of growing health workforce shortages

3.5 SUSTAINABILITY

38 This is not a sustainable picture. Even if the future was relatively benign, we would need to take action to lift performance and to bring the rate of health spending growth down to match the rate of growth in national income.

⁴ Medical Council of New Zealand.

⁵ *Report of the Director-General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards.* (2009). *Senior Doctors in New Zealand: Securing the Future.*

⁶ *Ibid*, p42.

4 Tomorrow's challenge

4.1 INCREASING PRESSURES ON SUSTAINABILITY

39 The outlook is anything but benign. The growth in health spending is forecast to continue to exceed income growth as, amongst other things, the population ages and as more of us live longer with chronic long-term conditions. Population ageing also means that the ratio of the working to the retired population will shrink significantly, concentrating this heavier spending burden on a relatively smaller group of workers and taxpayers. At the same time, there are increasing expectations on the health system to do more to prevent illness and improve the quality of life, especially as improvements in health technology make more interventions possible.

40 The projections that have been done for the next 20 years suggest that, assuming current models of care, real health care costs will almost double and that health spending will continue to out-strip income growth, to be about 50% higher as a percentage of GDP, so crowding out other social spending. If we do not change the way health services are provided, then this near doubling of service demand implies a near doubling of capacity to meet it i.e. nearly twice as many hospitals, doctors, nurses and so on.

41 The vulnerabilities we currently face are also likely to become more dramatic. International shortages in the health workforce are forecast to worsen and our ability to compete on pay is likely to fall further behind, especially compared with the high growth emerging market economies, like those in neighboring Asian countries. Regional service weaknesses will also become more striking. Six smaller DHBs are likely to face a shrinking and ageing population, along with a relative ageing of their workforce. This will make it increasingly difficult to sustain the current range of hospital services to an acceptable quality standard, especially given the degree of service vulnerability that already exists.

4.2 THE CHALLENGES AHEAD

42 The challenges implicit in the current situation are likely to get significantly worse as this outlook unfolds. The sheer size and immediacy of this challenge suggests that we need to move quickly on a number of fronts at once. We clearly need to shift health system performance so that it can continue to improve the level and quality of services while following a lower expenditure growth path over time; a more difficult task with an ageing population. This is likely to require a rethink about the way health services are provided in order to reduce health inflation and improve productivity, so that we can do more with what we have, both within public hospitals and across the system as a whole. It is also likely to require a much more deliberate debate about the range of health services publicly provided, especially as improvements in health technology expand the scope of services that could be made available.

The ratio of the working to the retired population will shrink significantly, concentrating this heavier spending burden on a relatively smaller group of workers and taxpayers

The Way Forward

5 Closer to home: new models of care

New models of care are important both to the efficiency and sustainability of the health system and to providing an improved patient focus which will see patients receive the treatment they need closer to home as more care is carried out through primary and community-based health services.

- 43 Lifting health system performance within a more constrained environment will require new models of care to ensure care is better integrated, so more people receive the right care delivered by the right provider at the right time. Continued emphasis needs to be placed on helping people to take greater responsibility for improving their own health, in terms of both prevention and treatment. Making healthier lifestyle choices around risk factors like drinking, smoking, eating, and exercising can make a big difference.⁷ Improving health literacy as well as the quality and accessibility of information and advice will continue to be important in this regard. Individuals and their families also need support to play a more active role in helping people manage their own care, especially for longer-term conditions, the care of older people and in terms of deciding about end-of-life care.
- 44 We will require a change in clinical culture so that there is a significantly greater degree of cooperation across community, primary, secondary, and tertiary providers to deliver truly patient-centric care and a seamless transition between different providers as individuals' health care needs change. This is the most challenging of all the changes that we will need to make because it requires changing the way health professionals work together across the whole health system. While there are many examples both in New Zealand and overseas of individual situations where a part of the system is well integrated, no country has really achieved this consistently system-wide. While governments can help create the incentives and provide support, success will depend on leadership by health professionals at all levels.
- 45 The benefits are substantial. Patient safety and service quality will be improved by, for example, reducing the risks associated with patient handover caused by fragmented care. Shifting some forms of care from secondary to primary and community settings provides more convenient care closer to home and at reduced cost, which helps stretch the health budget to deliver more and more timely care. More assessments and minor surgery, for example, could be shifted to a primary setting and primary and community providers can help DHBs better manage acute care by working more closely with hospital-based clinicians. Primary and community providers can help reduce avoidable hospital admissions and unplanned readmissions (through a focus on early intervention and supported self-managed care that helps keep people well at home) and provide a safe option for earlier discharge from hospital. Primary care providers could also be given stronger incentives for the more efficient and effective use of referred services (such as pharmaceuticals) as well as for reducing avoidable hospital visits.

We will require a change in clinical culture so that there is a significantly greater degree of cooperation across community, primary, secondary, and tertiary providers

⁷ Research by the Australian Institute of Health and Welfare shows that 32% of the burden of disease in Australia is due to seven risk factors which can be reduced or prevented by lifestyle and personal behaviour – factors such as smoking, obesity, physical inactivity, excess alcohol consumption, and poor nutrition. *A Healthier Future For All Australians Interim Report* (December 2008), p5.

46 Developing more integrated models of care should also help reduce inequalities, especially if other access barriers are tackled at the same time. Reducing inequalities has been an important feature of New Zealand health policy for almost 20 years. Although there have been areas of improvement, inequalities remain in terms of both access and outcomes.⁸ Reducing inequalities requires a systemic approach which addresses many barriers simultaneously. Barriers include: the range of costs of care, the communication skills of the provider, structural barriers to care, and the cultural fit between the patient and the provider.⁹ Developing new models of care is critical to addressing access as well as outcomes, particularly in the context of integrated models of care.

47 While there has been some solid progress made in isolated areas, we cannot rely on current arrangements to deliver the new models of care we need. Some DHBs and PHOs have launched some successful initiatives e.g. the Canterbury Initiative in Christchurch,¹⁰ various programmes in Counties-Manakau¹¹ and various PHO initiatives.¹² Moreover, clinical networks have been established that are making useful contributions in some specialty areas.¹³ However, progress in developing new models of care is slow and patchy and needs to be focused on both improving the patient journey as well as on specific conditions. It also needs greater focus on desired outcomes, like reduced acute demand or improvements in disease indicators (rather than clinical compliance with defined processes). It can be better, for example, to set a well-defined objective, like reducing acute hospital admissions, and leave clinicians to work with other health care workers to build the process to achieve it. More is required to develop existing successful programmes and ensuring they are replicated more broadly and extended to include community-based care.

48 The Primary Health Care Strategy (PHCS) envisaged that the PHOs it created would, amongst other things, improve the coordination of care including between primary and secondary care. Eight years after publication of the strategy, the OECD recently concluded that "...new models of care generally failed to take hold." They recommended that:

"The PHOs should either be eliminated as an unnecessary new bureaucratic layer or else their role and obligations must be more clearly defined, particularly as regards facilitating the development of new clinical models, with the DHBs using part of their funding to the PHOs as a lever." OECD Economic Survey of New Zealand (2009)

Reducing inequalities requires a systemic approach which addresses many barriers simultaneously

⁸ 'Not in My Hospital? Ethnic Disparities in Quality of Hospital Care in New Zealand: A Narrative Review of Evidence'. (2009). *Journal of the New Zealand Medical Association* (122): 1297.

⁹ Jansen P. (2006). *Maori Consumer Use and Experience of Health and Disability and ACC Services*. VUW Symposium: Wellington, NZ.

¹⁰ For example, the Canterbury Initiative focuses on better defining clinical pathways by collaboration of primary and secondary clinicians. These pathways "...aim to avoid needless referrals and hospital visits by ensuring ready access to diagnostic and specialist support in primary care and community settings." *Improving the Patient Journey*, CDHB. To date six pathways have been developed and operationalised with significant savings in hospital and outpatient attendances.

¹¹ For example, the Chronic Care Management Programme covers five chronic diseases, like diabetes, and a pilot for chronic renal disease and patients 'frequently admitted' to hospital that do not meet the other criteria. The Primary Options to Acute Care Programme provides funding to primary providers who can manage patients safely in the community who would otherwise be admitted to hospital.

¹² For example, ProCare's Chronic Care System is focused on supported self-management of chronic conditions and was recognised as the Best International Chronic Care Management Programme at the conference on Global Perspectives on Clinical Disease Prevention and Management, Calgary, Canada (2007).

¹³ For example, the regional cancer networks.

The Treasury has identified a number of fundamental limitations of the current PHO arrangements: weak financial incentives to adopt new forms of care; poor accountability relationships with practices; large variation in PHO capability; and unrealised contribution to wider system efficiency (e.g. unnecessary referrals for hospital-based specialist assessments may have actually increased scope for reductions in avoidable hospital admissions).¹⁴ NZMC data also suggests that, whatever the cause, there has been a reduction in hours worked by GPs since the introduction of capitation, with little compensatory increase in nurse practitioners.

- 49 While we accept the logic of the OECD recommendation above, we consider that PHOs should first be given the opportunity and encouragement to help develop new models of care. It is the responsibility of the DHBs to work with all providers to develop these new models of care, including by devolution to PHOs, when that is the best way of discharging that responsibility. In dealing with the full range of providers, DHBs will need to adopt a neutral position with respect to their own provider arm.
- 50 The MRG considers that deepening and broadening the current patchy progress towards the required changes to models of care requires action across five mutually reinforcing areas:

- **Stronger clinical networks in more places**

Clinical networks, which often also include managers and consumers, have been successful in some specialty areas in improving the coordination of care to deliver a more seamless experience for patients. For example, the regional cancer networks are important in bringing together all of the key people involved in caring for cancer patients in a way that can help address the problems created by fragmented care. More should be done to develop the influence of existing networks and develop new networks. These networks will need to be supported by the funder at the relevant level i.e. the NHB for national services and DHBs for regional and local services. Recommendations on establishing networks are included in Annex 2. Both the NHB and the DHB should be required to report annually on the development of these networks and assess their effectiveness.

- **Clarify the role of PHOs**

Their role should be to do more to keep people well; reduce avoidable hospital admissions and unplanned readmissions; to take responsibility for shifting services from secondary to primary settings when sensible; and to reduce unnecessary GP referrals.

The original specification of the PHO role in the PHCS was that PHOs become the coordinators of care for their enrolled population.¹⁵ If some PHOs are to be more than an “unnecessary new bureaucratic layer” then they must clearly demonstrate that they are actively working with DHBs and community providers to develop new models of care that deliver the above results.¹⁵ PHOs should be actively seeking to establish the protocols and arrangements with

It is the responsibility of the DHBs to work with all providers to develop these new models of care

¹⁴ Mays and Blick.(2008). *How Can Primary Health Care Contribute Better to Health System Sustainability: A Treasury Perspective*.

¹⁵ That included coordination with secondary care, public health, disability support, mental health, developing joint care plans with other providers and maintaining continuity of care for patients who have significant periods of care with other providers.

these other parties that will bring this about. Unless PHOs can do significantly more in the direction suggested above, questions need to be asked about the extent to which they are playing the role that they should be.

- **Develop the management capability of PHOs so they can take on a bigger role**

If PHOs are going to be able to play a greater role then we need to strengthen PHO management capability as well as their ability to take and manage financial risks. Paying much higher management fees to smaller PHOs reduces the incentive to amalgamate or cooperate in a way that allows for stronger management. Reducing the management payments made to those PHOs with less than 40,000 enrolled patients, and using the resulting saving to help them transition to a more capable configuration would help address this problem. Increased size would also allow PHOs to spread the financial risks associated with unanticipated demands from their enrolled population.

- **Require DHBs to play a more active role in developing new models of care and help them to do so**

DHBs should also be required to agree protocols and establish arrangements amongst community, primary, and secondary providers to facilitate the collective development of new models of care. This will require a clinically led process and needs to include strengthening the contractual and financial incentives on secondary, primary, and community providers to develop cost-effective substitutes for secondary care and to work together to develop new models of care that are patient-centric, less fractured, and more cost-effective. The Government has already taken a useful step in this direction by making money available to DHBs to work with PHOs to shift some secondary services to more convenient primary care settings (at no extra cost to consumers).¹⁷ DHBs should not be restricted to dealing with PHOs if direct agreements with others, like NGOs, can achieve the same ends. DHBs should also be required to broaden this effort to reduce avoidable hospital admissions and unplanned readmissions and to strengthen incentives for more efficient and effective use of referred services. If this risks spreading available funds too thinly, then it may be better to target funding to those DHBs, PHOs and other providers who are already well placed to make really substantial progress. The NHB should assume responsibility for the preparation of nationally consistent contracts that DHBs, PHOs and others might use for these purposes.¹⁹ The revised contracts should include some form of revenue and cost sharing around managing chronic long-term conditions, acute hospital demand (e.g. avoidable hospital admissions and unplanned readmissions) and referred services, where that is appropriate. DHBs should be required to report on the status of these protocols and contractual and financial arrangements as well as provide an assessment of their cost-effectiveness. The Ministry should also reassess the role of the PHO Performance Programme in the light of these broader developments.

If PHOs are going to be able to play a greater role then we need to strengthen PHO management capability as well as their ability to take and manage financial risks

¹⁷ The Minister's Letter of Expectations to DHBs asked them to "...build on the PHCS by shifting some secondary services to more convenient primary care settings (at no cost to patients)." The Government has allocated \$19.5 million of new funding over two years to DHBs to help kick-start this initiative and asked DHBs to identify in their DAPs those services that they are looking to shift to PHOs.

¹⁸ To date, PHO contracts have been reviewed by the PHO Service Agreement Amendment Protocol Group, which has made recommendations to the Ministry concerning revisions. The NHB may consider an alternative mechanism to the current process.

¹⁹ Trisha Greenhalgh et al. (2008). 'Introduction of Shared Electronic Records: Multi-Site Case Study Using Diffusion of Innovation Theory'. *BMJ* (337): a1786. They point to eight interacting influences that explained the mixed fortunes of the programme in its first year.

- **Health professionals across the different institutional settings would find it much easier to provide seamless care if they shared easy access to a common patient record**

Our IT recommendations support this development. However, success is much more than finding and installing the right technology. A fair measure of agreement about the models of care the technology is required to support before making a major investment, rather than relying on this investment to lead a change in the models of care. To be successful, a transferable electronic patient record needs to become part of the routine way health professionals work and work together. There is real advantage in starting to develop the ability of community, primary, and secondary clinicians to work together first, rather than relying on an IT project to 'push' these changes.

The MRG recognises the difficulty and dangers of trying to devise centrally-driven prescriptions for the way different providers should work together to develop the changes in models of care that are so important to sustaining and improving the performance of the health system. The health professionals involved, and the organisations they work for, are best placed to identify how these models are best developed. The Government does have an important role to play however in: creating a clear expectation in favour of new models of care; clarifying roles and responsibilities; requiring the organisations that it funds to report progress and assess the impact of changes; and to support these developments by providing some of the underlying technology and intellectual infrastructure.

The MRG recommends that the Government:

- (a) Require the NHB (for national services) and the DHBs (for regional and local services) to report annually on the development of clinical networks and assess their cost-effectiveness in helping to deliver seamless care for patients,*
- (b) Clarify that the role of PHOs is: to do more to keep people well; to reduce avoidable hospital admissions and unplanned readmissions; to share responsibility for shifting services from secondary to primary settings when sensible; and to reduce unnecessary GP referrals,*
- (c) Reduce the management fees paid to PHOs with an enrolled population of less than 40,000 and use the resulting savings to help these PHOs to transition to a stronger management configuration (e.g. via amalgamation, confederation, or some other arrangement for sharing managerial support – see Annex 4.3 for more detail),*

There is real advantage in starting to develop the ability of community, primary, and secondary clinicians to work together first, rather than relying on an IT project to 'push' these changes

- (d) Require DHBs to agree protocols and establish agreements, with contractual and financial incentives, among community, primary, and secondary providers to develop new models of care that are patient-centric, less fractured, and more cost-effective. This should include agreements to reduce avoidable hospital admissions and unplanned readmissions, to develop cost-effective substitutes for secondary care to strengthen incentives for more efficient and effective use of referred services. Financial incentives for risk sharing should be strengthened for those PHOs who already have the capability to manage the financial risks associated with taking greater responsibility for the health of their enrolled populations. DHBs should also be required to report on the development of these agreements and assess their cost-effectiveness,*
- (e) The NHB should assume responsibility for the preparation of nationally consistent contracts that DHBs, PHOs, and others might choose to use for the purpose of meeting the requirements in recommendation (d) above. These contracts should include some form of revenue and cost sharing where appropriate,*
- (f) Reassess the role of the PHO Performance Programme in the light of the development of these broader arrangements,*
- (g) Ensure that the NHB, DHBs and PHOs work together to develop shared electronic access to a common patient record based on a distributed approach (see Annex 3) and within a reasonable timeframe, and*
- (h) Within three years, the Government should seek an assessment of those PHOs that are not successfully meeting the requirements of their role with a view to removing them.*

6 Stronger clinical and management partnerships – giving doctors, nurses and other health professionals more say

It is essential that the culture of the health and disability sector change so that clinicians share accountability for decision-making, leading change, and achieving outcomes.

We will see better patient outcomes when clinicians are taking a lead in service improvements and planning.

51 Meeting the challenges facing the sector will require more active clinical engagement and combined clinical and managerial leadership across the sector. In the primary and community sectors, the focus needs to be on stronger cross-sector engagement and leadership with hospital colleagues. Meeting the challenges in the hospital sector requires more active engagement of doctors, nurses, and other health care workers – and stronger collective leadership from these clinicians in partnership with managers. There are some outstanding examples of successful clinical-managerial partnerships around the country. However, this needs to be more systematic and widespread: from front-line to service to institutional leadership, including non-medical health care professionals and embracing evolving models of care.

52 The report of the Ministerial Task Group on Clinical Leadership, *In Good Hands*, suggested that “...many clinicians have decided to abrogate the responsibility for managing the health system at many levels” and that “...many managers ...feel less and less able to influence the clinicians who deliver the healthcare and who determine the quality and safety, and cost, of that care.” Some hospital clinicians suggested to us that their views are too often ignored by management. We have received a number of reports of unfortunate situations, where committed, highly respected senior clinicians in the secondary sector, who have been engaged in management roles, finally out of frustration, have resigned from those roles. Managers, on the other hand, suggest that clinicians often leave the hard choices for management to resolve.

53 This sort of stand-off serves neither the community nor health sector professionals. The Medical Council of New Zealand is clear that, “...doctors have a responsibility to the community at large to foster the proper use of resources and must balance their duty of care to each patient with their duty of care to the population.”²⁰ The challenges we face require collective leadership from both clinicians and managers to help find the appropriate answers. Failure to do so will not only undermine service quality and performance, it will also leave governments facing greater cost pressure and with cruder options for cost containment. This outcome would eventually undermine what each clinician is able to do for the patient in front of them.

Meeting the challenges in the hospital sector requires more active engagement of doctors, nurses, and other health care workers

²⁰ Medical Council of New Zealand. *Statement on Safe Practice in an Environment of Resource Limitation*.

54 The discussions we have had over the past six months lead us to conclude that the barriers to greater clinical leadership in New Zealand are very similar to those found elsewhere. A recent McKinsey review, *When Clinicians Lead*, identifies three main issues that stand in the way of enhanced medical leadership in hospitals: scepticism among doctors about the value of diverting time from clinical practice; weak incentives and some strong disincentives to greater clinical engagement (including disdain from peers for clinicians who reduce clinical practice to take on leadership roles); and little provision for developing or nurturing of clinical-leadership capabilities. These issues are discussed in more detail in Annex 2.

55 We support a focus on the following four areas:

- Demonstrate to clinicians and managers that this is worth their time. Identify the behaviours and leaders that have been successful and the good they have been able to do for their patients and their teams. Collect and distribute credible evidence around these benefits,
- Strengthen incentives and remove disincentives. Credible and timely performance data allows clinical and financial improvements to be identified, measured, and supported. Clinical leadership needs to be valued and seen to be important, and clinicians not disadvantaged by taking leadership roles. Formal clinical leadership roles should be recognised by the allocation of sessional time during the working week to fulfill their duties. Clinicians who are willing to step up and engage in efforts to improve performance should be an integral part of the decision-making process, with substantive influence and with real accountability for the results,
- Clinical-management partnerships that succeed should be offered more flexibility to manage their own affairs. We have been impressed with examples of clinical groups within public hospitals who have assumed overall responsibility for an area of service delivery and achieved increases in efficiency. This model seems to work best when kept simple and when the unit operates in a way which enhances its working relationships with other parts of the hospital. Clear objectives for the unit are important as are agreed principles guiding how it will work positively with others and contribute to the success of the whole organisation. Explicit agreement between clinicians and managers about the aims of the service and how they will work together are necessary from the beginning and should reduce the need for over-reliance on complex and overly formal rules. In some cases, good results have been achieved by enabling the service to use an agreed proportion of any savings they make to reinvest in the service, and
- Identify, develop, and support good clinical leaders and managers as well as the behaviours that underpin successful partnerships, with common aims. Identify potential leaders early and engage them in performance improvement initiatives. Put more effort into leadership training, as well as coaching and mentoring future leaders.

*Clinical leadership
needs to be valued
and seen to
be important*

The authors of *In Good Hands* were asked to focus in particular on strengthening clinical governance i.e. that DHB Boards be responsible for ensuring a high standard of clinical care as well as their corporate and community responsibilities. Without progress on the issues identified above and, in particular, the more detailed recommendations in Annex 2, there is a real risk of mandating a form of clinical engagement without sufficient substance i.e. of eliciting little more than 'tick-box' compliance. As they note themselves, "Clinical engagement is about more than simply appointing people to particular positions or forming committees." On the other hand, if the substance is strengthened then the form should follow, so we are cautious about being too prescriptive around the form of clinical engagement and involvement in decision-making. We are also mindful that clinical leadership is a means to various ends, rather than an end in itself, and is likely to be most rewarding when those ends are well specified. We support their recommendations that DHBs be required to report on clinical outcomes and effectiveness, although we would leave the onus with DHBs to identify the safety and quality targets that made most sense to them and their clinicians (as long as progress towards similar targets selected by different DHBs are measured in a nationally consistent way).

The MRG makes a number of recommendations on enhancing clinical leadership and engagement, including through greater use of clinical networks. These are included in Annex 2.

7 Improving patient safety and quality of care

An improved quality of care will result in better outcomes for patients and reduced costs – which in turn will allow more treatment and better access to services.

- 56 Stronger clinical-management leadership is particularly important to improving patient safety and service quality. These are currently areas of “slow and patchy” progress, according to the Health and Disability Commissioner. They are also areas where we should be able to simultaneously improve health outcomes and reduce costs. Improving patient safety by reducing preventable harm caused by health care management is typically the first step on the journey of improving service quality by encouraging best clinical and managerial practice.
- 57 Most patients receive good care most of the time. However, the literature suggests that there are substantial human and financial costs associated with medical error, such as prescription and surgical errors and preventable infections. Davis et al found that 12.9% of people admitted to hospital suffered an unintended injury caused in the management of their conditions, rather than the underlying disease.²¹ This is similar to results for comparable countries. About 80% of these ‘adverse events’ occurred in the hospital and although most had relatively minor impact on patients, about 15% resulted in permanent disability or death. Importantly, only 6.3% of admissions were associated with potentially preventable, in-hospital adverse events. These errors added an average of nine days to the expected hospital stay of these patients. Subsequently, Brown et al estimated the cost of these adverse events in public hospitals in 2001 that were deemed preventable was \$590 million. Harm was defined as preventable if the doctors reviewing the evidence “...agreed that it was due to a failure to follow accepted practice at the individual or system level.”²² Their results suggested that up to 20% of the cost of public hospital expenditure goes toward treating potentially preventable adverse events.
- 58 If we just consider potentially preventable events that occur in hospital alone and adjust it for increased volumes and prices since the study was done, then about 44,000 people would have suffered harm via an adverse event in 2009 with a conservative cost of about \$570 million.²³ Using Brown’s 20% estimate and applying it to current hospital spend would put the figure closer to \$800 million (so a figure somewhere between \$600 million and \$800 million is probably correct). We need to recognise that some element of human error is unavoidable and focus our safety efforts on anticipating what could go wrong and establishing systems and procedures to prevent it. Successful safety programmes in other countries have been able to make solid gains reasonably quickly. If we take the bottom end of the savings estimate of \$600 million and assume that it would take five years to make half the total available savings, then that would represent potential savings of about \$60 million per annum in hospitals alone. Depending on how this process is managed, these potential savings can be translated

They are also areas where we should be able to simultaneously improve health outcomes and reduce costs

²¹ Peter Davis et al. (2002). ‘Adverse Events in New Zealand Public Hospitals 1: Occurrence and Impact’. *The New Zealand Medical Journal* (115): 1167.

²² Brown et al. (2002). ‘Cost of Medical Injury in New Zealand: A Retrospective Cohort Study’. *The Journal of Health Serv Res Policy* (7): Suppl 1.

²³ Estimate based on CPI adjustment of costs, which would understate health inflation (we gratefully acknowledge the work of Alan Cumming in Counties Manukau DHB in updating the figures). Using Brown’s 20% estimate and current hospital spending the figure would be closer to \$800 million.

into a combination of actual savings, increased throughput, reduced bed utilisation, and/or a delay in the need to build new hospital bed capacity. An increased focus on realising these potential gains will be required in order to lift performance within a more constrained budgetary environment.

- 59 Given the potential for substantial health and financial gains, this is an obvious area to look to DHBs to deliver ongoing productivity gains. Previous governments have already made a significant contribution to kick-start a national safety and quality programme e.g. in terms of establishing the Quality Improvement Committee (QIC), centrally funding around \$27 million of QIC's safety and quality initiatives, and then adding a 0.25% performance payment in the 2008/09 DHB funding round tied to progress on five QIC safety and quality initiatives. This has since been incorporated into the DHB funding base and so now automatically grows with that base.
- 60 QIC initiatives such as safe medication management, management of health care incidents, optimising the patient journey, and infection prevention and control started in mid-2008 and are expected to produce real health and financial benefits to DHBs when fully implemented. To be successful, safety and quality programmes need to become 'business as usual' for DHBs who should assume the funding for them. DHBs will need to realise the financial benefits from these programmes, and from their successors, to help them live within a slower funding growth path and deliver ongoing service improvements.
- 61 If the Government is going to ask DHBs to deliver ongoing productivity gains from safety and quality programmes, then it needs to strengthen the ability of the centre to help DHBs deliver, for three main reasons:
- The financial incentives on DHBs may lead them to under-invest in safety and quality. While these investments should reduce cost and free up bed capacity, the potential revenue benefits are indirect and arise from the ability to use this capacity to increase electives. While we should start to look at introducing safety and quality premiums and discounts in elective pricing, this only represents a small proportion of DHB activity,
 - Some of the things that need to be done can only be delivered collectively, like developing and collecting the comparative data that is so important for demonstrating and motivating success, and codifying what works into standards and guidelines that apply across the whole sector, and
 - It is often more cost-effective to provide many of the functions of a well-designed and implemented safety and quality programme centrally. We need to leverage the experience of local centres of excellence across the whole system and to leverage the best international experience and expertise for the benefit of New Zealand as a whole. However, programmes will need to be responsive to local needs and conditions and to what clinicians see as their most pressing safety and quality issues.

QIC initiatives such as safe medication management, management of health care incidents, optimising the patient journey, and infection prevention and control started in mid-2008 and are expected to produce real health and financial benefits to DHBs

62 There is also real benefit in broadening the centre's focus beyond hospitals and DHBs, to include the rest of the sector. For example, IPAC and RNZCGP are sponsoring a 'Quality Information for General Practice' (QI4GP) programme which will invest in clinical technology, information, and processes. This includes updating and modifying the Practice Management Systems for the GP that should help deliver safer and better quality primary care more equitably and efficiently. The programme also aims to reduce unnecessary hospitalisations and improve performance measurement. With respect to the latter, there is real scope to use the improvements in the GP Practice Management System to address the serious weaknesses that currently undermine the effectiveness of the around \$30 million the Government sets aside each year to fund incentives paid out under the PHO Performance Programme.²⁴ After discussions with the PHO Performance Programme governance group, the MRG concluded that the Government would be better off scaling back payments due under the programme for a period and use the resulting savings to help accelerate introduction of QI4GP.²⁵

63 The MRG proposes that we strengthen and broaden the role of the centre by:

- (a) Establishing an independent national quality agency with responsibility for helping providers across the whole sector improve patient safety and service quality. It needs to be independent of the regulatory, funding, and performance monitoring agencies of government, report directly to the Minister and have its own dedicated staff. Its role would include working with local and international experts to develop a menu of 'certified' programmes which can be adapted for local needs and environments, with clinicians and managers choosing those that are most likely to mobilise local clinical support and are best suited to their local needs. The agency would also: develop safety and quality standards and guidelines; benchmark and gather comparative data on what works and why; run workshops aimed at helping clinicians and managers to make improvements; and publish national reports of quality indicators e.g. serious and sentinel events, and
- (b) Building on the foundation programme initiated by QIC to develop the next phase of national quality and safety programmes that address patient safety and continuous quality improvement.

²⁴ For example, feedback to us from the General Practice Leaders Forum who reported a high level of dissatisfaction with the programme and cited a number of problems, from a lack of GP engagement that was associated with high numbers of GPs reporting that their clinical behaviour and patient care was not influenced by the programme through to concerns about data accuracy.

²⁵ In particular, the upgrading of GP's practise management systems in a way that will strengthen the incentive impact of the PPP. Given how confident the QI4GP sponsors are in the ability of the project to help in reducing unnecessary hospital admissions, some of these savings could be recycled in the form of a commercial loan to GPs for upgrading their practice management systems, with the loan written off as targets for reducing these admissions are met.

In the first instance, national safety and quality programmes that are designed for DHBs, as well as a proportion of the agency's time spent working with DHBs, should be funded by top slicing the DHB funding formula. The agency should charge private providers who want to use it for managing the implementation of agency-certified programmes. While the sums of money involved are unlikely to be large, this keeps responsibility with the providers, both for funding the programme and delivering their health and financial benefits. At some point, this agency should become more independent of government and be funded by a mixture of fee-based quality programmes and financial subscriptions from public and private member organisations. This would provide a real test of the value added by the agency to the regulators, funders, and providers whose activities it supports.

64 Sustainable safety and quality improvements cannot be 'mandated and forced' on the sector. Clinical and management leadership is critical, as are clear measures of progress, as well as feedback to clinicians on what works best. These measures should be used for demonstrating and motivating success. Rather than imposing a new set of safety and quality 'targets' from the centre, we should ask clinicians to build on the initiatives already underway and add what they see as most important to saving lives and preventing harm in their organisations from the menu of nationally 'certified' programmes. There is no need for New Zealand to work in isolation or reinvent the wheel here. There is an international body of evidence and well-developed approaches around what works, along with local and international expertise to help us design and implement programmes to suit the New Zealand environment. The Institute for Healthcare Improvement (IHI), for example, has a successful track record in many countries and already informs the development of our national quality agenda.

65 The culture of this new agency needs to be underpinned by strong leadership that inspires, persuades, guides, supports, and works with the sector to advance a sustainable national quality programme. It is important that this organisation has a role in continuing the development of safety and quality standards and guidelines that underpin the quality improvement process. It is equally important, however, that this organisation is not a regulator of providers or a funder of safety or quality programmes. Certification of providers is the role of the Ministry. Similarly, funding quality programmes should be the responsibility of DHBs and private providers who must support these programmes if they are to succeed.

We should ask clinicians to build on the initiatives already underway and add what they see as most important to saving lives and preventing harm

The MRG recommends that:

- (a) The quality programmes initiated by QIC are used as a foundation to develop the next phase of national quality and safety programmes that address patient safety and continuous quality improvement. Existing initiatives should become business as usual for DHBs, who should assume the funding for them as the existing QIC budget is worked through,*
- (b) The current PHO Performance Programme should be scaled back for a period and the resulting savings used to help accelerate the introduction of quality improvement for primary care using the Q14GP as a starting point,*
- (c) An independent national quality agency is established to replace QIC and with responsibility for helping providers across the whole sector improve patient safety and service quality, with the following roles and characteristics:*
 - (i) The agency is independent of the regulatory, funding and performance monitoring agencies of government, reporting directly to the Minister and with its own staff,*
 - (ii) The agency's role should be to: develop a menu of 'certified' programmes for providers to choose from; develop safety and quality standards and guidelines; benchmark and gather comparative data on what works and why; run workshops aimed at helping clinicians and managers to make improvements; and publish national reports of quality indicators e.g. serious and sentinel events,*
 - (iii) The agency should act to ensure sector buy-in to its programmes, recognising that programmes will not be sustained if they are mandated and forced on the sector,*
 - (iv) Agency funding should be a mixture of top sliced PBFF (recognising the proportion of the agency's time devoted to DHBs), and charging private providers who want to use it for managing the implementation of agency-certified programmes, and*
 - (v) At some point, this agency should become more independent of government and be funded by a mixture of fee-based quality programmes and financial subscriptions from public and private member organisations.*

8 Identifying the services people need: funding new services

Patients will benefit from the introduction of new clinical procedures and medical devices which have been assessed for their safety and effectiveness while the efficiency of health services nationally will improve from their effective prioritisation.

66 An important determinant of health system sustainability is the ability to meet public expectations for improved services within available resources, especially as improvements in health technology make more interventions possible. For some years now, DHBs have enjoyed an additional 0.5% annual increase to their population-based funding as a 'technology adjuster' to meet these demands. There are also a number of new initiatives each year that are considered in the normal budget process.

67 Current capacity to assess and prioritise new health interventions for public funding is mixed. Pharmac is well regarded and has developed widely accepted processes for assessing the relative cost-effectiveness of new pharmaceuticals and making well-informed judgments about priorities for public funding of new and existing pharmaceuticals. It acts as a negotiating agent for the DHBs, and also assesses the cost-effectiveness of new drugs before putting them on the Pharmac drug 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.

68 Outside pharmaceuticals, however, the current mechanisms for assessing the effectiveness and relative priority of health interventions are not as well developed. Strengthening these mechanisms will help improve the value and control the cost of improvements in health technology. In particular, the MRG considers it both possible and desirable to develop a Pharmac-like process for assessing the cost-effectiveness of medical devices and prioritising them for public funding. We also recommend strengthening the role of the NHC to assess the extent to which new health interventions should attract public funding and selectively reviewing funding for existing interventions.

Current capacity to assess and prioritise new health interventions for public funding is mixed

8.1 MEDICAL DEVICES

69 Unlike pharmaceuticals, while medical devices have to be registered with MedSafe there is currently no pre-market check of their safety, or any systematic assessment of their cost effectiveness or relative value, or any national procurement aimed at reducing the cost of purchasing devices and supplying them to hospitals. The MRG is recommending action to address all of these deficiencies:

- As part of the current process for updating Medsafe’s therapeutic products and medicines legislation and developing joint regulatory capacity with Australia, the scope of Medsafe’s activities should be extended to cover regulation of the safety of medical devices. Given the scarcity of regulatory expertise, this could involve a process for recognising the regulatory decisions of similar jurisdictions as applicable in New Zealand, at least in the first instance,
- That when it is possible for Pharmac to assume responsibility for a nominal budget for medical devices from DHBs, then Pharmac should assume the same responsibilities and apply the same processes to these devices as it currently does for pharmaceuticals. While the initial focus might be on new devices or existing devices where a nominal budget can be agreed, it will need to develop a process for considering all devices within this framework over time,
- For a device that costs over a certain figure, the NHB will assess this as a request for new capital equipment as part of its mandate to prioritise DHB capital requests (using Pharmac advice on its effectiveness), and
- With regard to devices, the new national procurement agency (see Section 12) will gradually assume responsibility for those purchasing and/or supply chain management functions used in public hospitals that cannot be managed by Pharmac when the conditions set out in Annex 4 can be met.

These changes should improve the safety and reduce the cost of medical devices used in New Zealand, and in public hospitals in particular. Part of reducing the cost of devices will occur as a result of reducing their proliferation and so simplifying their purchase as well as the management of their supply from the manufacturer to the hospital.

There is currently no pre-market check of their safety, or any systematic assessment of their cost effectiveness

8.2 HEALTH INTERVENTIONS

70 In May 2005, the NHC reported on the way decisions were taken to introduce new health interventions because it was concerned that there was no systematic process for assessing new interventions before they were introduced into the health system (and therefore were publicly-funded).²⁶ These decisions were (and remain) largely made independently by individual DHBs. The NHC report identified a number of serious deficiencies in the decision-making process around introducing new interventions e.g. that these processes were not comprehensive, were easy to avoid, had limited stakeholder involvement beyond clinicians, and were typically not based on a synthesis of all available evidence and information. Moreover leaving decisions to individual DHBs, or more often to specialties within DHBs, created problems of duplication, did not allow a comparison of relative benefit and had unintended consequences for both other areas of care and on other DHBs (as raised expectations created a 'domino effect'). The NHC considered that "...priority should be given to developing robust decision-making processes and to improving the capacity and capability for assessing evidence and information." In particular, it recommended that "...inter-DHB processes are required for decisions about interventions or services that would be costly and inappropriate for each DHB to provide individually." In the opinion of the MRG, this recommendation should include major new diagnostic procedures and interventions (such as PET) as well as new treatment interventions.

There was no systematic process for assessing new interventions before they were introduced into the health system

71 The NHC recommendations were taken up by the Ministry, which worked with DHBs to develop the SPNIA framework that aims to help DHBs and the Ministry with health service changes that required a collective decision.²⁷ Despite the best efforts of those involved, this approach has struggled to address the issues raised by the NHC. Shortcomings arise in part because of the way the framework is governed and supported and in part because of the lack of influence over the funding decisions taken in response to its recommendations. For example, an individual DHB is still able to offer a new intervention, with the unavoidable risk of flow on to other DHBs, even if everyone else involved in the process considers that intervention too experimental and not clearly cost-effective.

72 The MRG considers that the problems identified by the NHC and listed above can only be successfully addressed by a single national agency removed from both DHBs and the Ministry. The best approach would be to strengthen the NHC itself to assume the role of assessing and prioritising all significant new diagnostic procedures and treatment interventions. This role fits squarely with the primary statutory purpose of the NHC as described in section 13 of the Act.²⁸ An essential component of this strengthening is to ensure the agency has the capability to conduct evidence-based assessment of the likely costs and benefits of new and existing

²⁶ National Health Committee. (2005). *Decision-Making about New Health Interventions: A Report to the Minister of Health*.

²⁷ SPNIA is the Service Planning and New Health Intervention Assessment framework. See Ministry of Health. (2006).

Service Planning and New Health Intervention Assessment: Framework for Collaborative Decision-making.

²⁸ The NHC's statutory purpose as described in section 13 of the NZHD Act i.e. to "...advise the Minister on the kinds and relative priorities of health and disability services that should be publicly funded."

procedures and interventions. The Government would also need to reconsider membership of the NHC to ensure it has the range of expertise needed to undertake this new role.

The NHC would also have to act within a defined budget for new interventions that was determined by the Minister. This will need to be determined as part of the budget process and taking into account likely savings from discontinuing existing interventions. The actual budget could then be passed through to the relevant funder (DHBs, NHB or the Ministry) as final decisions were made.

73 The NHC would be responsible for determining which procedures and interventions would be eligible for public funding and the conditions under which they should be applied (e.g. eligibility and location), as well as the net cost of new eligible procedures and interventions. For example, as well as defining the patient group most likely to benefit, a new treatment might only be suitable for trial, or for use in tertiary hospitals, or in situations where everything else has failed an individual patient. The NHC should be required to identify existing interventions that should be replaced in due course as a result of newer and better interventions it is recommending. As part of its prioritisation process, the NHC should also be asked to identify and assess a number of existing interventions annually that, in the opinion of the NHC, the Minister or the Ministry appear to be low priority (e.g. have uncertain or relatively little health benefit net of the harm they cause). This should include existing health services whose application may have been extended beyond the point where significant net health benefits are demonstrable.

74 The NHC would assess new interventions submitted by the Minister, the Ministry, the NHB or DHBs (either acting on their own or as sponsor of requests from other health organisations) for public funding. This would include any new interventions that meet the current SPNIA conditions as well as any that would require increased current expenditure to the health and disability system as a whole of more than \$5 million. The Minister would require the NHC to prioritise new interventions on the basis of their cost-effectiveness and identify the process that the NHC must apply in making its decisions (such as any requirements for consultation, consideration of ethical reviews, publication of the decision and its rationale including the evidence on which the decision was made).

The NHC should be required to identify existing interventions that should be replaced in due course as a result of newer and better interventions

75 The alternative to giving the NHC the budget would be to leave the budget, and the final decision on adopting those new interventions deemed eligible for public funding by the NHC, in the hands of the DHBs. This approach would, however, create differences in the service mix at different DHBs and a degree of 'post code' access to new services.

76 This proposal would address the problems originally identified by the NHC and described above: it would be comprehensive, difficult to avoid, involve a wider group of stakeholders, and would be based on all the available information. Moreover, it would overcome problems of duplication in the assessment and provision of new procedures and interventions by individual DHBs, as well as allowing for an assessment of both the relative effectiveness and the whole of system impact of new health interventions.

77 The MRG conclusions on the above issues are very similar to those of Prof. Munn, who conducted a separate and parallel review of the SPNIA process.²⁹ He suggested that the existing SPNIA approach should be abandoned and replaced with:

- An agency that was similar to, or an expansion of, the Pharmac model to assess and procure medical devices on behalf of DHBs (e.g. using a similar approach to the assessment of medical devices that Pharmac applies to pharmaceuticals). Prof. Munn also suggested that we introduce safeguards for medical devices that exist for medications, either via upgrading the functions of Medsafe and/or an amalgamation with the Therapeutic Goods Administration in Australia, and
- An independent agency to evaluate new and existing healthcare services. This agency would assess new and existing services based on their cost utility to determine which services should have restricted access, which should be removed from the publicly funded menu, and which new services deserved to be added and under what conditions.

78 The MRG recommendations are for service prioritisation 'at the margin', rather than the more comprehensive approach first envisaged for the predecessor of the NHC and tried in some jurisdictions offshore. The MRG considered the experience in New Zealand and overseas with attempts to try and assess and prioritise all services and identify those 'core' services that should be publicly funded. We concluded that this was unlikely to succeed in the current environment. In any event, our more modest approach would probably be a useful prerequisite even if a more ambitious approach was to be contemplated in future.

that we introduce safeguards for medical devices that exist for medications

²⁹ Prof. Stephen Munn. (2009). Personal communication.

The MRG recommends that the SPNIA process be abandoned and replaced with:

- (a) A reconfigured and strengthened NHC with the role of evaluating all new – and an ongoing selection of existing – health and disability services. This role to include:
 - (i) Assessing the extent to which new health and disability services are clinically safe and should attract public funding based on their effectiveness and cost,*
 - (ii) Determining the conditions under which new publicly funded services should be made available, including the eligible patient group, restrictions on the provider (e.g. tertiary hospitals only) and/or the situations in which the new service should be used (e.g. trial only),*
 - (iii) Selectively reviewing funding for existing interventions to identify which should no longer qualify for public funding based on their effectiveness and cost,**
- (b) That when it is possible for Pharmac to assume responsibility for a nominal budget for medical devices from DHBs, then Pharmac should assume the same responsibilities and apply the same processes to these devices as it currently does for hospital pharmaceuticals,*
- (c) A new national procurement agency recommended in Section 12 below ‘Shifting resources to the front-line’ should establish a process for gradually assuming responsibility from DHBs for the collective procurement of, and managing the supply chain for, medical devices used in public hospitals that are not managed by Pharmac, and*
- (b) The scope of Medsafe’s activities be extended to cover regulation of the safety of medical devices, in conjunction with the Therapeutic Goods Administration in Australia. Given the scarcity of regulatory expertise, this could involve a process for recognising the regulatory decisions of similar jurisdictions as applicable in New Zealand, at least in the first instance.*

9 The right service in the right place: changing service configuration

A better national and regional service configuration should improve the clinical and financial viability of public access to specialist services.

79 Section 3 (5) of the Health and Disability Act requires the Crown and DHBs to “...endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services.” The original idea was for the Ministry to gradually devolve its funding and planning functions to DHBs which would collaborate to develop regional and national decision-making structures. After nine years, the reality is that the Ministry is still planning and funding about \$2.5 billion of NDE and the regional and national structures developed by DHBs are not well developed and remain dependent on the ongoing support of each of the 21 DHBs, where the ultimate authority resides. This situation is self-reinforcing. One of the main arguments against further devolution of Ministry-funded services is that 21 individual planning and funding functions are simply not well enough developed, either locally or regionally.

80 This slow and fragile evolution has rendered the health and disability system unable to deliver the optimum arrangement of services. It has also left the Ministry being asked to do far too much across far too diverse a spectrum of activity, reducing its effectiveness. Rather than being able to focus on its core policy and regulatory functions it also been asked to manage \$2.5 billion of funding, run a number of diverse national operations (including running a large payments business), and intensively monitor the 21 DHBs.

81 Achieving the “...optimum arrangement for the most effective delivery” of services will require stronger institutional arrangements at all three levels: national, regional, and local. It will also require a transparent process for engaging clinicians in deciding the level at which services should be planned and funded and how that should change over time. National services need to be defined and then the planning and funding of these services properly managed. DHBs need to be required to plan and fund regional services and create a robust structure for planning, funding, and delivering those services. The Ministry needs to devolve its funding function to the right level, and shed the national operations functions that are not important to its regulatory role to a new national shared service, and its detailed DHB-level monitoring functions into the NHB which should be given specific responsibility for service and capacity planning and funding (refer Annex 4). That would also provide a clearer separation between the development of health policy and its implementation which would force greater policy clarity and consistency around what those charged with implementation were required to achieve. The NHB would not represent a duplication of the Ministry and increased bureaucracy. Across the two organisations there would be less staff in total and much clearer roles and accountabilities.

It has also left the Ministry being asked to do far too much across far too diverse a spectrum of activity, reducing its effectiveness

9.1 NATIONAL SERVICES

- 82 There is widespread recognition that 21 individual DHBs are not well placed to determine the best national configuration for the provision of high-cost and low-volume services that rely on the support of a national, or at least super-regional, population base for their ongoing viability such as: paediatric sub-specialties; forensic psychiatry; genetic services; heart, lung, and liver transplants; major burns; cardiac surgery; and neurosurgery. These services are currently provided in a few centres and secure a large proportion of their funding from outside their domicile DHB through inter-district flows (where the provider charges other DHBs for patients from their district that are treated by the provider). The DHBs making these inter-district flow payments simply reimburse the provider for the patients from their district that are treated by the provider.
- 83 The MRG is recommending that a positive list of national services be defined and the planning and funding of these services should be done at the national level by the NHB. Funding for national services should be provided by top slicing the PBFF. The national organisation would contract with some DHBs to deliver these national services for the entire country. Such contracts will recognise out-reach services that are provided regionally and locally in order to extend coverage and complement national provision. To be successful in this role, the NHB would need to involve clinical networks in the process of determining service access criteria and service design, and in a substantive way.

9.2 REGIONAL SERVICES

- 84 The Government has recognised the importance of greater collaboration among DHBs in the planning and funding of services. DHBs are starting to look more seriously at cooperating for regional service planning, funding, and provision in order to improve the quality of care as well as reduce service vulnerability and cost. However the incentives for regional cooperation are not strong and this cooperation will always be vulnerable to parochial interests being asserted on any issue, at any time, and by any one of the cooperating DHBs.
- 85 We propose that DHBs be required to produce Regional Service Plans (RSPs) across a wide range of services. While DHBs have been moving in this direction, the current lack of a formal requirement for these plans makes it harder to ensure that the right care is delivered in the right place at the right time. A greater focus on organising service delivery on regional lines should also help reduce service vulnerability and ensure that services are organised around the size of population best able to ensure their clinical and financial viability into the future, which in turn helps provide certainty to the workforce and consumers alike. The initial RSPs should focus on planning and funding for vulnerable services as well as those whose longer-term clinical and financial viability clearly depends on servicing a larger, regional population. This will include some secondary services, where they meet these criteria. Service vulnerability is

The incentives for regional cooperation are not strong and this cooperation will always be vulnerable to parochial interests

usually the result of workforce shortages, and/or safety and quality concerns, that make it difficult for hospitals to sustain acute medical and surgical services. Service vulnerability can be reduced by DHBs working more closely together in service planning and delivery, as was envisaged in section 3(5) of the Act which requires DHBs to endeavour to provide services to be organised either locally, regionally, or nationally. Requiring RSPs provides a 'missing' mechanism to help achieve that aim.

- 86 Given that responsibility for funding services for their populations rests with DHBs, they will need to delegate responsibility for developing and implementing RSPs. This is fully consistent with DHB legislative responsibility and will provide a better outcome for their populations when regional organisation produces higher quality care or greater clinical and financial viability. We recommend that this authority be delegated to Chairs and CEOs to make decisions on behalf of their DHB at the regional level. The Chairs and CEOs of the constituent DHBs in a region would then become the regional service's governance body accountable for the development and implementation of the RSP. Each constituent DHB's District Annual and Strategic Plans would need to be consistent with the RSP.
- 87 Constituent DHBs would also need to reallocate a proportion of their existing planning and funding staff to support the development and implementation of the RSP. This will not require any additional staff; indeed there should be some efficiencies in planning and funding regional services once rather than replicating that across the constituent DHBs. This could build off the existing shared service companies that already exist in each region, and so should not require any additional organisational overhead. Stronger regional planning and funding functions would also support the further devolution of service planning and funding functions currently managed by the Ministry.
- 88 There will inevitably be rare occasions where the Chairs and CEOs of constituent DHBs can not agree on which services should be planned and funded (and/or provision organised) at a regional level. There needs to be some mechanism for resolving these disputes in a way that is binding on the parties and that moves everyone towards "...the optimum arrangement for the most effective delivery of properly co-ordinated health services" (section 3(5) of the Health and Disability Act 2000). We propose that these disputes be escalated to the NHB for resolution. We could foresee a process where the NHB appoints suitably qualified experts to advise it on the most clinically and financially viable option that delivers a quality service. This could be achieved by the Minister making it clear that he will require these regional and NHB decisions to be reflected in each year's Crown Funding Agreements and District Annual Plans. Nothing in this process precludes the Minister from referring any issues for expert review, should the need arise.

There needs to be some mechanism for resolving these disputes in a way that is binding on the parties and that moves everyone towards "...the optimum arrangement for the most effective delivery of properly co-ordinated health services"

89 Making this greater regional focus work will require the active cooperation of clinicians and managers. In respect to the organisation of service delivery, DHBs will need to work through how a greater regional focus will affect existing expectations about how and where clinicians and managers might be asked to work. This is particularly important for new employees, who need to know that they are joining an organisation that takes responsibility for clinical services across a broader geography than has been the case in the past.

9.3 LOCAL SERVICES

90 We are not proposing any changes to the planning, funding, and provision of local services, as these will still be managed by the individual DHBs with direct accountability to the Minister. However, the scope of services provided locally by DHBs is likely to increase as the Ministry devolves more of the services that it currently plans and funds. We are also proposing that the accountability and funding of DHBs be moved from the Ministry to the NHB. That fits with our proposal that the NHB has responsibility for service planning and funding and will also help in focusing the role of the Ministry on its core policy and regulatory functions. We are also proposing that the NHB be responsible for managing the process and advising the Minister on which services should be planned and funded at the national, regional, or local levels.

9.4 CONCLUSION

91 Leaving the evolution of the current framework to the cooperative efforts of 21 DHBs, each with an effective veto on any issue at any time, is going to be slow and fragile and will create its own set of frustrations for those trying to make progress. The proposals suggested here will allow us to accelerate the evolution of the current DHB-based model towards one that better balances local, regional, and national interests within the current legislative framework. There will be some structural change: significant change to the role and functions of the Ministry of Health, as well as a rapid acceleration towards more of a regional planning and funding focus in the DHBs. However, a stronger national and regional planning and funding capability represents 'missing links' in the current model, the lack of which severely undermines its ability to meet the challenges ahead.

Will allow us to accelerate the evolution of the current DHB-based model towards one that better balances local, regional, and national interests

The MRG recommends that:

- (a) The Minister establish a positive list of national services that will be planned and funded by the NHB and financed by top slicing the PBFF currently allocated to DHBs for that purpose. The NHB would then contract with a selection of DHBs to deliver these national services for the entire country,*
- (b) The NHB establish a transparent process for advising the Minister about which services currently planned, funded, and provided at the national, regional, and local levels should be organised at a different level in future,*
- (c) DHBs be required to produce RSPs across a wide range of services. The initial plans should focus on planning and funding for vulnerable services as well as those whose longer-term clinical and financial viability clearly depends on servicing a larger, regional population,*
- (d) DHBs be asked to delegate authority to their Chairs and CEOs to make decisions on their behalf at the regional level and who will become the regional service's governance body accountable for the development and implementation of the RSP,*
- (e) In those rare cases when DHBs cannot agree on the RSP, these disputes be escalated to the NHB for resolution and that it identifies the most clinically and financially viable option that delivers a quality service,*
- (f) The NHB contract on behalf of the Minister with DHBs for regional and local service and planning, and delivery, and monitor DHB performance, thus taking this function out of the Ministry,*
- (g) That 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) and advise the Government accordingly (Annex 4), and*
- (h) That the Ministry of Health's role focuses increasingly on providing policy advice, administration of regulations, monitoring the NHB, and servicing the Minister's office.*

10 The right capacity for the future: making better investments

The right investment decisions will ensure capacity to deliver the right care in the right place at the right time

- 92 Forecasts for the next 20 years suggest a near doubling in real health spending. If service configurations and models of care stay unchanged, that suggests a near doubling of current capacity to provide that service. Moreover, the existing service vulnerability in a number of small DHBs will come under greater pressure as their populations are expected to shrink. Leaving capacity decisions to be largely driven at the local DHB level, and within the context of a single-year planning cycle, means that we are likely to keep investing in the way we currently do things. When coupled with the difficulty of changing work roles and practices, this locks us into what is an increasingly unsustainable: configuration of facilities; hospital-based models of care; rigid job definitions and work practices; as well as disconnected and institution-centric (versus patient-centric) technology investments. Not only will this produce a capacity ill suited to meet future health needs, it will also lock us into the sort of cost growth implied by current forecasts.
- 93 We can only meet forecast service growth with a sustainable cost track if we invest in doing things more efficiently. For example, the Government is keen to deliver care 'closer to home' (described in Section 5) so that primary health care and home-based care substitute for hospital-based care when that produces an equal or better outcome. Encouraging greater primary and community capacity to support this vision will only reduce overall cost, however, if this investment really does substitute for more expensive new hospital capacity. If investment in new hospital facilities and the workforce is unchanged, then this secondary capacity is likely to be used and the extra primary and community capacity simply adds to overall capacity and health cost growth. We need to develop sound links between long-term strategic plans and investments and robust processes for ensuring that such investments anticipate future models of care. These processes will also need to ensure that changes aimed at substituting for hospital-based care will actually achieve that objective.
- 94 The current capital allocation process has a number of weaknesses which mean it is more likely to replicate current arrangements than produce a national allocation of investment that is best suited to future needs (see Annex 3). The National Capital Committee (NCC) is tasked with bringing a national perspective to the process. However, its coverage of the national capital spend is incomplete, it only prioritises on an annual basis, and there is an over-emphasis on the local perspective (in large part because there is no coherent longer-term national perspective that it is working towards). By effectively operating on a one-year horizon the NCC only prioritises current cases against the presently available capital envelope. The relative priority between DHBs between years is not assessed and neither are future phases of a multi-phase investment within a single DHB. Over-emphasis on district (versus national)

Not only will this produce a capacity ill suited to meet future health needs, it will also lock us into the sort of cost growth implied by current forecasts

perspectives risks duplicated investment that undermines the viability of capacity in another DHB which can result in under-utilised capacity (due, in part, to a lack of coordinated national services and/or workforce planning). Some of the people involved in the NCC process also point to the lack of a transparent and independent decision-making framework, one that is overly reliant on subjective factors, the availability of internal DHB funding, and lobbying. A number of people from different agencies have pointed to the need to: lengthen the capital planning horizon; develop clearer regional and national perspectives; and improve the transparency and independence of the decision-making framework. Clearer regional and national perspectives require clearer views about how and where services should be provided at a national and regional level. We are proposing that the NCC be replaced by the Investment Committee of the NHB.

95 The current decision-making framework around investments in IT also suffers serious weaknesses. Our position as a world leader in many areas of health IT, particularly in primary care, is slipping. Despite having had a Health Information Strategy for New Zealand (HISNZ) since 2005, progress has been slow due to lack of national strategic leadership, changes in policy settings, a lack of alignment, and funding issues. While IT investment proposals over \$3 million require Ministerial approval, there is a great deal of confusion around the decision-making process and investment criteria. The sector, including the Ministry, is struggling to cope with a myriad of IT projects.

96 We propose addressing the weaknesses in the current system by lengthening the planning horizon and making the new NHB responsible for capacity planning and funding. This would ensure that:

- Investment in new capacity is driven by a longer-term view of the services that capacity is required to deliver (including the service configuration and new models of care that underpin those services). Longer-term service planning needs to drive capacity planning (or else, reinvesting in current service configurations and models of care will drive future service delivery, quality, and cost),
- Workforce, facilities, and IT investment decisions are well coordinated which is necessary to ensure that the resulting capacity is fully utilised (e.g. that new facilities are properly staffed and without draining staffing capacity from existing facilities in other parts of the country), and
- The decision-making process would be more transparent and independent because of the separation of the NHB from the Ministry. There would also be a transparent process for deciding which capacity decisions would be made at the national, regional, and local levels and how those allocations would evolve over time. While the NHB would advise the Minister on these changes, the Minister would also have the independent views of the Ministry to call on.

Progress has been slow due to lack of national strategic leadership, changes in policy settings, a lack of alignment, and funding issues

With respect to IT, we recommend that the HISNZ and the IT investment programme be refocused around current government priorities, and on implementation of the priority elements of the HISNZ, and that the Ministry's ID focuses largely on the Ministry's own IT needs. The current Ministerial IT Advisory Committee (HISAC) should be disbanded. The NHB should establish a single investment committee responsible for planning, funding, and working with the sector to implement and advance the health IT agenda as part of its broader IT and facilities investment programme.

97 When the budget constraint on capacity is less binding, there is less need for a well-developed priority setting process. In future, this constraint is likely to become far more binding which will make the priority setting process much more important. A much better developed process that brings service and capacity planning together within a stronger decision-making framework is essential to ensure that we can deliver 'more and better' health services for this given expenditure.

98 We are suggesting that the NHB be separate from and monitored by the Ministry for four main reasons:

- Separation allows the Ministry to focus on its core policy and regulatory tasks and the NHB to focus on its core implementation tasks, improving performance in both. Greater focus will allow a simplification and unification of the diverse groups, including the numerous committees, that are currently active in each area,
- Separation allows independent monitoring, assessment, and reporting of the performance of the NHB and of those functions transferred to the NHB. The Ministry cannot credibly monitor its own performance, so if this were to be done by the Ministry then the Minister would have no independent source of advice on this performance. While this adds a new monitoring function (i.e. the Ministry monitoring the NHB) this function generates real benefits,
- Separation forces greater clarity around the objectives for, and operational parameters of, the implementation functions that will now be carried out by the NHB. Ministers must be explicit about their expectations of what they want the NHB to achieve and how it should go about it, and
- As a Crown Entity the NHB is more distant from the Minister which, when combined with greater clarity around the 'rules of the game' (see above), should provide greater confidence about how the NHB will behave. This reduces both the reliance on subjective factors and the scope for lobbying and special pleading. If Ministers want a different outcome than the process would generate, then they need to state that explicitly. This greater independence is likely to be particularly important when disputes amongst DHBs on RSPs are elevated to the NHB and when it comes to ranking capital investment proposals.

Separation allows the Ministry to focus on its core policy and regulatory tasks and the NHB to focus on its core implementation tasks, improving performance in both

A brief pictorial description of the proposed structure, along with the roles of the NHB, the Ministry of Health, and the DHBs is provided in Annex 1. Because the new national organisation exercises at the national level many of the responsibilities that the DHBs exercise at the local level, we have provisionally called it the National Health Board (NHB). This is no more than a convenient label. Formally, the functions ascribed to the NHB in this report would be transferred to the CHFA, who would operate as the NHB (with the Minister considering if the current board of the CHFA would need to be reconstituted to meet its new roles).

The MRG recommends that:

- (a) The roles and functions ascribed to the NHB in this report would be transferred to the CHFA, who would operate as the NHB. The Minister will need to reconsider the current membership of the CHFA Board in order to ensure that it is best placed to manage its new roles and functions. As part of the transition arrangements, a temporary establishment board might be appointed to manage the transition, and*
- (b) The proposed NHB is made responsible for capacity planning and funding, including workforce, capital, and IT. Detailed recommendations for addressing the capacity planning issues discussed in this section are found in Annex 3.*

11 Building a sustainable workforce

Simplified and unified national planning and more flexibility in work roles and practices is required to ensure that we have the health and disability workforce we need to provide quality patient-focused health and disability services throughout the country.

99 One of the most significant challenges we face is training and retaining the workforce we need, while reducing the risk that wage cost inflation will reduce the quantity of services we can deliver from a limited budget. A recent review of how the training of the New Zealand health workforce is planned and funded found that we had significant problems in recruiting, training, and retaining adequate numbers of health and disability workers and that these problems were likely to grow with time.³⁰ The Chair of that Review, Prof. Des Gorman, notes that in the context of a current global shortage of health workers New Zealand is the most reliant country in the OECD group on overseas trained doctors and nurses. According to the Medical Council's workforce survey, about 40% of the medical workforce are international medical graduates and they are very mobile, with only 50% of international medical graduates retained in the year immediately after initial registration.³¹ Given that New Zealand lags behind the OECD in terms of national income and income growth, we are not in a strong position to compete internationally on the basis of higher salaries. Trying to compete on this basis will mean that even more of the health budget will be consumed by wage and salary costs, leaving less money to provide health and disability services. Increasing training places can help play a part, but it will simply add to cost unless we can retain those we train.

100 Current models of care and increasing sub-specialisation are substantial drivers of increased cost. Doctors and nurses are encouraged to specialise. Specialties, and sub-specialties, become silos which make patient-centric care more difficult. Moreover, each 'new' specialty needs to have additional juniors, nurse specialists, and so on to look after a specific condition or illness. The reality is that many people have multiple illnesses and require a patient-centric multi-disciplinary team approach. Whatever the cause, there is a general trend to higher cost and lower quality with an increase in specialists per capita and a decrease in cost and increase in quality with an increase in GPs per capita.³² Stronger clinical networks, new models of care, and a supported generalists' workforce working in a multi-disciplinary team offers better prospects for improved patient care, quality, and productivity.

New Zealand is the most reliant country in the OECD group on overseas trained doctors and nurses

³⁰ Personal communication from the Chair of that Review, Prof. Des Gorman.

³¹ Medical Council of New Zealand. (2008). *The NZ Medical Workforce in 2008*, p27. Only 31% are still working as part of the New Zealand medical workforce after three years.

³² See for example, Starfield and Sha. (2002). *Health Policy* (60): 201-218; Franks and Friscella. (1988). *Journal of Family Practice* (47): 105-109; Buiker and Chandra. (2004). *American Economic Review* (94) 357-361.

101 Training and keeping the workforce we need while also containing wage inflation will simultaneously require: a smarter approach to developing the workforce skills we need; measures to help improve job satisfaction; better utilisation of workforce capacity; and improved workforce productivity, especially via greater flexibility in work roles and practices. This will require action across six areas:

- The simplification and unification of the existing workforce planning and funding efforts across the sector (see Annex 3). In particular, we propose that the NHB create a National Health Workforce Board (NHWB) for this purpose. This will ensure that workforce planning is well integrated into the wider process of service and capacity planning,
- Greater flexibility in the creation of new roles as well as the definition of existing roles and scope of practice, and making it easier for existing health workers to acquire additional skills to take on wider roles,
- Greater flexibility in work practices and a faster and wider spread of the best work practices,
- Improving the configuration of service delivery across the local, regional, and national levels so that scarce professional skills are better utilised,
- Better use of technology to improve clinician collaboration and to better utilise and economise on those specialist skills in shortest supply, and
- Improving working conditions and job satisfaction e.g. by more effective clinical engagement, less paperwork, and improved hospital systems.

The MRG recommends in Annex 3 the creation of a NHWB inside the NHB that will, together with the NHB, be tasked with helping advance the objectives in the list above. The suggestions for improved job satisfaction via more effective clinical engagement, less paperwork, and improved hospital systems are reflected in our recommendations on strengthening clinical engagement and leadership (Annex 2) and on IT (Annex 3).

12 Shifting resources to the front-line

A focus on shifting resources to the front-line will improve public access to a wide range of health and disability services.

102 Pharmac does extremely well in containing pharmaceutical cost growth. We need to adopt a similar approach to other non-wage costs in back office areas that all DHBs have in common, in order to free up resources for front-line care. While the 21 DHBs are making some progress in collective management of some back office functions through regional shared service companies and national collaboration (via DHBNZ), this progress is slow and fragile. It requires the agreement of the constituent DHBs to act and, even then, any DHB can opt out of the arrangement. The proposed solution to this problem is the creation of a Pharmac-like national shared services organisation that can gradually take over responsibility for those common back office services that currently support DHB operations and that are referred to it by the Minister.

103 To be effective, this organisation must have the mandate to act on behalf of DHBs, as Pharmac does for pharmaceuticals. While it would be possible to bind DHBs contractually via an agency agreement to this national organisation, we see merit in establishing it as a Crown Entity with its own legislation. This organisation would assume responsibility for existing shared service arrangements (e.g. health payments) and obvious candidates for nationalisation (e.g. procurement and supply chain management) and, over time, be tasked with working through the entire range of common DHB back office services (e.g. payroll and finance systems). Specialist functions, like payments, would be best managed via subsidiaries that would be able to recruit specialist expertise onto their boards. Given that it would take some time to enact the required legislation, we propose that the NHB assume this role in the meantime and be charged with establishing appropriate subsidiaries for existing shared services and a process for working through the range of potential candidates. This new organisation would, along with some of the other changes suggested by the MRG, assume many of the current functions of DHBNZ whose ongoing role would need to be reviewed by the DHBs to determine what additional capacity they still required to work collectively at the national level.

The proposed solution to this problem is the creation of a Pharmac-like national shared services organisation that can gradually take over responsibility for those common back office services that currently support DHB operations

The MRG recommends:

- (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 (Annex 4), and*
- (b) The NHB be required to:*
 - (i) 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 (Annex 4), and*
 - (ii) Depending on how long it will take to establish the proposed national shared service agency, manage the existing three shared service functions that we propose be shifted out of the Ministry and into the national agency (i.e. Healthpac, Audit and Compliance, and Health System Reporting Information).*

13 Getting more from our public hospitals: improving hospital productivity

Improving hospital productivity will see greater volumes of surgery and better access to services.

104 Many of the suggestions discussed in this report will also help strengthen hospital productivity. Improved patient safety can produce significant savings in bed-days as well as reduce preventable harm. Many of the service quality improvements can also generate significant productivity gains by reducing patient waiting, streamlining the patient journey, and so on. More flexible workforce and work practices will improve labour productivity in the hospital. More efficient national procurement of hospital supplies and management of other hospital back office and support services will also help. Better aligning investment in facilities, workforce, and IT in the hospital sector will help ensure that capacity is better utilised in the areas of highest benefit. A more rational allocation of services across regions and across the country will also help ensure that hospital capacity is used more efficiently and to greater effect. Finally, a better allocation of activity between hospital-, community- and home-based care will help ensure that specialised hospital services are better deployed.

105 Those responsible for monitoring the effectiveness of health spending need reliable and comparable productivity measures at the hospital level and, to the extent that it is feasible, at the level of the system as a whole. These measures need to be produced by a credible, expert and independent source.

106 DHBs, hospital managers, and clinicians are likely to be more focused on the opportunities for improving performance at a less aggregated level. There is much to be gained by reducing the substantial gap between the best and worst performers within and between hospitals. This requires an independent set of productivity measures at the appropriate level that are credible, useful, and make sense to those hospital clinicians and managers who are best placed to make productivity improvements within the hospital. It also requires a forum for effective discussion amongst clinicians about the results and the sorts of practice changes required to deliver improvements. This would complement the approach we have suggested to improving patient safety and service quality. The Government should consider how it might encourage DHBs to strengthen their capability in this area. In the meantime, DHBs should be required to identify the three or four productivity measures each year that are the most important to them and report their progress against the improvement targets they have set themselves.

A more rational allocation of services across regions and across the country will also help ensure that hospital capacity is used more efficiently and to greater effect

The MRG recommends that:

- (a) DHBs be required to identify the top three or four productivity measures each year that are most important to them and report progress against the improvement targets they have set for themselves, and*
- (b) The NHB should ensure that:*
 - (i) Productivity measures should be developed for use at system and hospital level. These should be developed by a credible, expert, and independent source, and*
 - (ii) Clinical productivity measures should be developed at the appropriate level, with strong clinical input.*

14 Further work

107 As we worked through our terms of reference, we identified seven areas which have important implications for the sustainability and performance of our public health and disability system that require further work.

14.1 DISABILITY SUPPORT SERVICES

108 The health and disability support needs of people living with disabilities are growing strongly. These services are funded through at least 12 different government agencies and provided by a huge diversity of public and private organisations, including NGOs. Contracting for service is fragmented and lacks coordination which leads to variations in service and access throughout the country and diversion of effort into contracting, reporting, and auditing activities rather than service provision. Funding ‘buckets’ are seen to be too rigidly tied to specific purposes and contracting too focused on the service provided rather than meeting genuine needs and producing improved outcomes. There is a concern that this rigidity often leads to providers defaulting to relatively expensive care options. For example, residential care or specific home help may be provided but assistance with specific tasks outside of these narrow ranges cannot be provided even if it would be more effective in maintaining independence at home. There is also a widespread concern about the lack of training, low levels of pay, and relatively high turnover of those who work in the sector. There is a need: for greater co-ordination and simplification of funding, monitoring, and auditing arrangements; for more flexibility in funding arrangements; and for more outcome-based monitoring and auditing.

109 It is important that the Ministry provide an early assessment of the issues raised above and consider opportunities for improvements prior to any further devolution of service funding and planning.³⁴ It also needs to consider what services should be funded and planned at national, regional, and local levels.

14.2 SERVICES FOR OLDER PEOPLE

The demand for services for older people is expected to grow strongly with the ageing of the population, especially those over 85 years. These services face many of the same issues and potential problems as those for people with disabilities. In many cases, they are dependent on the same assessment processes and involve the same providers. While there is very little national service funding to devolve there is a need for coordinated national planning for services for the elderly and oversight to ensure consistent service provision and coverage in what will be a growing area of service need. In particular, there is a need to ensure that the expectations of various service providers are transparent and widely understood and that contracts support the continuous and effective prevention and management of the complications of chronic disease and of disability across providers.

Funding ‘buckets’ are seen to be too rigidly tied to specific purposes and contracting too focused on the service provided rather than meeting genuine needs and producing improved outcomes

³⁴ Areas for particular attention include: identification of the optimum model(s) of care mix to meet increasing service needs; opportunities for cross-government working and consistency in entitlements; the level and amount of resource dedicated to planning and funding at the national level; rationalisation of business and contractual processes including payment processes; the mix of national and local contracting; the potential for partnership approaches with clients and providers; measures for monitoring service performance including potential outcome measures; opportunities to streamline auditing processes; human resource issues within the sector; and the role of the NASC and whether the assessment/coordination and budget allocation functions can be re-aligned.

14.3 MENTAL HEALTH

110 The MRG is recommending that the Ministry assess the scope for the further devolution of many of these services to DHBs at either the local or regional level. This will include the funding of the ring-fenced mental health budget that is currently with the Ministry. Part of the reluctance to devolve mental health funding has been a concern over the capability of all 21 DHB planning and funding functions to assume this responsibility. This concern will be addressed to some degree by the development of a stronger regional planning and funding capability as DHBs respond to the need to develop regional service plans. The Ministry will need to develop criteria: for the devolution of mental health planning and funding to national, regional, and local levels; for assessing the readiness and capability of DHBs to assume this responsibility at regional or local levels; and for monitoring the development of services over time.

14.4 NON-GOVERNMENT ORGANISATIONS (NGO)

111 NGOs play a significant role³⁵ and have a long history of providing front-line care, especially in disability support, addiction, and mental health. Traditionally NGOs are not-for-profit and independent of government, albeit often receiving government funding. They benefit from volunteer contributions and so often provide more service for limited funding.³⁶ They are typically relatively flexible and innovative in meeting consumer needs, in part because they are less limited by the constraints of public ownership and funding. NGOs have an important role to play in the development of new models of care that seek to move care 'closer to home', so it is important that they be well integrated into the wider health and disability sector.

112 The dilemma for NGOs is to keep the balance between the innovation, flexibility, volunteerism, and private financial support against the constraints that inevitably come from contracting with public agencies to deliver publicly-funded services. This tension could be eased by streamlining many of the standard contracting, auditing, and compliance processes so they better reflect the situation of different NGOs, reduce the frustrations that undermine their ability to focus on performance, and allow more discretion in their ability to tailor their services to meet the individual needs of their clients. Given the diversity of NGOs, however, this is not something that we have been able to address adequately in the time available.

They benefit from volunteer contributions and so often provide more service for limited funding

³⁵ It is almost impossible to quantify the number of NGOs but best estimates put the figure at 1,335 organisations within health; these are mainly across the mental health, addiction, and disability sectors.

³⁶ NGO services are characterised by innovation, flexibility, and responsiveness to community need. The NGO share of Vote Health has been estimated at nearly \$2 billion (Ministry of Health estimates) of which 60-70% is spent on staffing. For example, the 2004 VAVA report (PriceWaterhouseCoopers) identified that in general voluntary groups provide \$3 to \$5 worth of service for every \$1 of funding.

14.5 PREVENTION VERSUS CURE

113 It is reasonable to assume that New Zealand's relatively strong commitment to preventative and public health has helped improve life expectancy, delay the onset of disability associated with chronic disease, and reduce inequalities. Opinion is divided, however, on the much narrower question of the extent to which further spending in this area at the expense of more immediate health needs might help reduce future health costs or improve the country's economic performance, thus making future health spending more affordable.

114 On the question of cost, it is not clear that living longer and generally healthier lives will necessarily reduce our demand on health and disability services over our lifetime. Half of all health spending goes on the last year of life and the older we are the more likely we are to suffer from multiple conditions. In addition, many of us will live longer with long-term chronic conditions, like diabetes, that are expensive to treat and increase the risk of multiple conditions later in life. Information is needed on the impact of preventative and public health interventions on lifetime health and disability costs to guide future investment decisions in these areas.

115 On the question of health as an investment in growth, there is also a balance to be struck between the negative effects of the taxation required to finance health spending and the benefits of a more productive and longer lived workforce. Even if the potential benefits are significant, the effect of other policies on realising this potential will often be far more important. For example, the potentially large productivity benefits from people living healthier lives into older age will not be realised unless people also delay retirement.³⁷

14.6 FASTER ACCESS TO ELECTIVES

116 The growth in elective procedures has lagged the growth in the age-adjusted population, despite population-based funding intended to allow those DHBs with rising populations to increase elective services in line with demand, and an additional and specific budget top-up aimed at increasing elective procedures and public elective capacity. A combination of other local priorities, health cost inflation, and acute demand growth has crowded out elective procedures in public hospitals. Building new specialist regional elective surgical theatres and training additional people to operate them will increase elective surgical capacity. Private hospitals also provide specialist elective capacity and smarter use of this could help further reduce elective waiting times.

A combination of other local priorities, health cost inflation, and acute demand growth has crowded out elective procedures in public hospitals

³⁷ We still aim to retire at 65 years of age, the age of eligibility for the original Old Age Pension in 1898 when the life expectancy was 59 years, some 20 years shorter than it is today.

117 Current arrangements leave it to DHBs to contract with private hospitals to supplement public elective throughput. This is unlikely to make the best use of total public plus private capacity or provide the private hospitals with sufficient certainty to encourage additional investment. Moreover, the arrangement is institution-centric; unless they can afford to pay for private insurance, patients go where they are told and when space can be found for them. There are a number of ways to make the system more responsive to patients via a more neutral approach to funding public and private hospitals. However, the assumption is often made that workforce capacity is fixed, fully and efficiently utilised, and is the binding constraint on elective numbers. In this case, any funding shifted to private hospitals simply shifts workforce capacity out of public hospitals and risks adding to cost pressure. These assumptions are worth testing because if they are false then a more neutral approach to funding is likely to increase overall elective capacity and allow more people to be treated sooner. On the other hand, if they are true then increasing the elective pool with fixed elective workforce capacity is likely to simply increase the cost of a given volume of elective procedures.

118 One approach that might be worth exploring in more depth would be to trial the allocation of some of the elective budget to a PHO that was willing to work with either private or public hospital specialists to deliver more elective services (including post-operative care and follow-ups) to their patients on the public waiting list for the current national price. It would require business rules to guard against selecting the easiest cases, protect training opportunities for the next generation of specialists, and to meet the cost of any complications requiring intensive care should they arise, so it would not be straightforward. Reporting and compliance would also need to be worked through. However, the potential for a more integrated approach to improve the utilisation of scarce specialist skills and so increase overall elective capacity seems worthy of further exploration.

An effective model of integrated laboratory service provision should reduce the duplication of services

14.7 DIAGNOSTIC SERVICES

119 Laboratory services alone have been informally estimated to account for approximately half a billion dollars of health and disability system expenditure per annum. They include private community laboratory services, DHB laboratory services (sometimes provided by private laboratories), and reference services, and are purchased independently by 21 DHBs and the Ministry of Health. Service access is inconsistent across the country, in terms of both the range of services available (e.g. variable access to specific genetic diagnostic services for inherited conditions) and the cost of services to the consumer. An effective model of integrated laboratory service provision should reduce the duplication of services (particularly more specialised services) and minimise costs, while ensuring the planned development of appropriate nationally available levels of service capacity and capability as new technologies and methods are introduced.

120 Radiological services account for at least \$50 million of public hospital DHB expenditure with additional community service expenditure. The major area for concern here is the potential for either duplication of service provision or non-provision of new technology where the costs of entry into new areas of service provision are respectively relatively low or too high for any one DHB or region to consider.

121 We also recommend that the NHB initiates at an early stage a detailed review of the arrangements for the planning, funding, and provision of national, regional, and local laboratory and radiological diagnostic services with a view to determining the optimal planning, funding, and service configuration arrangements for New Zealand. While acknowledging that both public and private providers have a role to play, the mix of public and private provision and the 'playing fields' in which they operate should be included in the review. New diagnostic and interventional procedures costing more than \$5 million to introduce (including both capital and initial operating expenses) should be reviewed prior to their introduction to ensure that services are cost-effective and will improve health outcomes. The role of regional and national clinical networks needs to be considered in this review and in the context of the consideration by the NHC of new service introduction.

The MRG recommends that the Ministry report on 14.1 and 14.3 above and, within its first year of operation the NHB:

- (a) Reviews the arrangements for the planning, funding, and provision of national, regional, and local laboratory and radiological diagnostic services with a view to determining the optimal planning, funding, and service configuration arrangements for New Zealand, and*
- (b) Reports to the Minister on how to best address the other issues raised for further work in this section of the report.*

15 Conclusion

122 Left unchanged, the current DHB- and PHO-based model of health delivery is likely to rapidly generate an unsustainable tension between the community's expectations of the public health service and the community's ability to finance those expectations. It will almost certainly fall well short of the desire to lift health system performance over time within a more sustainable slower spending track.

123 The proposals suggested here will help relieve that tension and give us a much better chance of sustaining our public health system within the current legislative framework. The recommendations fill a number of important gaps in the current framework, especially in terms of:

- Encouraging greater clinical-managerial leadership,
- A better basis for determining access to public funding for new services,
- A stronger basis for national and regional decision-making and support around safety and quality, service configuration, and capacity utilisation and investment, and
- An improved framework for encouraging the more rapid development of new models of care.

The suggested changes will require a significant rearrangement of responsibilities at the centre. They will also require a commitment from DHBs to an approach that imposes some real discipline on them in terms of supporting stronger regional collaboration around the organisation of services and national decision-making, around those things they have in common. Provided this commitment is forthcoming, however, it should prove possible to devolve more of the \$2.5 billion currently funded by the Ministry to DHBs to plan and fund at either the regional or local level, if agreed by the Government.

124 The MRG has taken this approach because we considered that it was possible to lift the performance of our public health system and limit the rate of spending growth at the same time and within the current legislative framework. That judgement is based on our assessment of the scope to do more with what we have, the growing recognition of the need for change to meet the challenges we face, and the widespread desire amongst those we spoke with to make the system work better for consumers. Without legislative change, the success of our recommendations will largely depend on the willingness of the sector to make the sort of changes we are suggesting. For example, DHB Boards will need to accept a more disciplined framework to govern the way they work together, both regionally and nationally. No-one can be certain at this point that the changes we are suggesting will be sufficient to meet the challenges we face. More fundamental change may well prove necessary if the current legislative framework cannot be made to work in a way that meets those challenges.

The MRG recommends that, within three years, the Government:

- (a) Seeks an assessment of the extent to which the public health and disability sector is likely to be able to continue lifting performance without requiring an ever larger share of GDP, and*
- (b) Identifies the changes in the New Zealand Public Health and Disability Act 2000, or replacement legislation, required to simultaneously secure the sustainability and lift the performance of the public health and disability system so it is ready to introduce these changes if a change in the legislative framework is deemed necessary following the assessment in (a) above.*