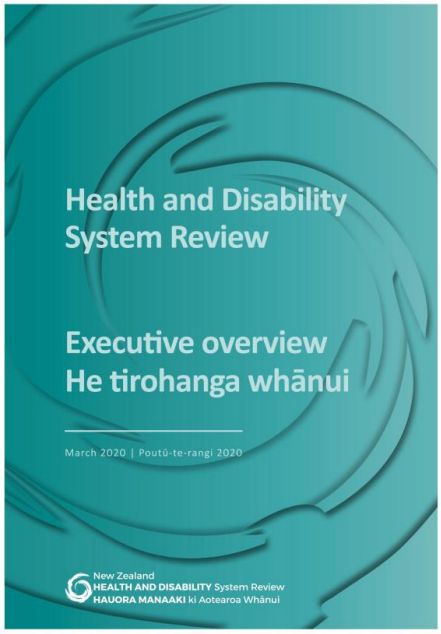
Commentary on the Health and Disability System Review

This is an analysis of the Health and Disability System Review, which was released on 16 June. ASMS' Research and Policy team has summarised the proposed changes and has gone through and identified relevant issues or concerns.

As a general comment, it is now well-recognised that a key determinant of performance in complex systems like health care services is the quality of interactions and relationships at every level within and between organisations. The Review, however, tends to focus mostly on structural changes. As one commentator put it, "the planned change is largely an exercise in anatomical realignment or structural change. There is less emphasis on the physiology of the system…". Partly as a consequence, while there are many potentially positive recommendations, they raise many questions as to detail and implementation.



These are the main changes being proposed in the Review:

- A new structure for the health and disability system
- A streamlined Ministry of Health
- The creation of Health New Zealand
- The creation of a Māori Health Authority
- A reduction in the number of DHBs
- The creation of a Health Strategy and a New Zealand Health Plan
- Changes to the workforce
- Changes to how facilities and equipment are managed.
- Changes to funding arrangements
- Changes to services
- Introduction of digital and data processes

A new structure for the health and disability system

The Ministry of Health (MoH) will be smaller and more focused, there will be a new Māori Health Authority, and a new organisation, Health New Zealand (HNZ), will provide the services through DHBs and so on.

A streamlined Ministry of Health

The MoH would become the "chief steward" of the health system, working alongside the Māori Health Authority (MHA). MoH would focus on developing policy, developing legislation, and providing leadership.

Creation of Health New Zealand

Health New Zealand (Health NZ) will be a Crown entity, completely separate from the MoH. Health NZ will have 50:50 Crown–Māori representation on its board and will develop the principles and rules for health service commissioning as it relates to Māori equity and wellbeing in partnership with the Māori Health Authority.

Creation of a Māori Health Authority

The Māori Health Authority (MHA) will report direct to the Minister of Health. It will sit alongside the MoH and will have similar functions relating to Māori health as the MoH does to health in general. It will take over all the functions of the Māori Health Directorate.

The MHA will be responsible for monitoring and reporting on Māori health outcomes, managing Māori workforce initiatives, controlling Māori-specific innovation funds, and advising Health NZ, the MoH, and the Minister of Health. The stated purpose is to enhance rangatiratanga (authority, ownership, leadership) and mana motuhake (self-determination, autonomy). There is no final recommendation for how it will be funded.

The Review Panel did not reach consensus on whether the MHA should control funding and commissioning of services for Māori. An alternate proposal from some members is included in the Review.

As part of the Review's strong emphasis on improving, Maori health outcomes, Te Tiriti will be fully incorporated into the health and disability system, and Mātauranga Māori will be embedded into all services.

General observations

- It is not clear how the shared focus on equity will be maintained across the MoH, Health NZ, and DHBs.
- It is also not clear how the proposal honours Te Tiriti o Waitangi, particularly rangatiratanga and mana motuhake.
- The overlapping roles present some big risks of confusion, conflict, and fuzzy accountability. These are not reasons for not having an MHA but rather highlight the need for very clear delineation of roles, processes, and accountabilities between these agencies. For it to work, relationships will need to be extraordinarily strong.

A reduction in the number of DHBs

The number of DHBs will be reduced to no more than 12. The reasons behind this are around improving efficiency. The Review wants DHBs to be more:

- accountable for health outcomes and equity
- collaborative across regions and so reduce costs
- streamlined in decision making.

General observations

- It is not clear how this would bring about improvements as there are many potential issues with mergers.
- The devil is in the detail but there would need to be a lot of relationship-building within and across DHBs before they would be ready for any mergers.
- We would also be concerned about the potential for the clinical voice to get lost if executive decision makers were too far away from the clinical coalface.
- Significantly increasing the size of DHBs also seems to run counter to the recommendations for stronger community engagement and for services to be defined locally according to the specific needs of individual communities.

As well as reducing the number of DHBs, the Review proposes an end to board elections, which will be replaced by a "competency-based approach" to select board members, whom the Minister would appoint. Local communities would be able to nominate individuals, but DHB employees would not be eligible.

Creation of a Health Strategy and a New Zealand Health Plan

The Review strongly endorses this as a way of moving towards more equitable outcomes and evidence-led improvements. It proposes that a New Zealand Health Plan (the Plan) be developed that looks ahead at least 20 years and includes "greater detail on actions in the first five years" and will be refreshed every five years.

General observations

- ASMS is supportive of this approach. It is heartening that clinicians should be better supported to engage in planning activities. However, this will only be possible if the workloads of clinicians are made more manageable.
- Integrating services across primary care and hospitals and having hospital and specialist services operating within a national plan is much needed but there is little discussion on how to go about successfully integrating services, despite some very promising internationally recognised work in New Zealand to provide guidance on this.
- ASMS wants to see more emphasis on public accountability and suggests cross-party support will be crucial for the success of these changes.

Changes to funding arrangements

The Review recognises that future funding arrangements need to be more responsive to changing cost pressures, population growth, and health need. It suggests that Vote Health allocations are given greater certainty, particularly in terms of guaranteed increases each year.

General observations

- The proposals are generally positive, at least in principle.
- It remains a concern, though, that the Review cites the need for improvements in "efficiency and productivity [to] mitigate concerns". It sees DHB deficits as evidence of inefficiency and poor service design, despite many years of under-funding.
- One notable proposal is that funding for Tier 1 services (primary care) be ring fenced to guarantee "confidence to the public and to the Government that funding is being used appropriately". On the face of it, this sounds reasonable but would depend on the adequacy of DHB funding overall. It is heartening that the review recognises "significant investment in hospital facilities would be required to address capacity issues", but the concern is that ring fencing primary care funding could be at the expense of hospital care.

Changes to services

The Review proposes a new framework for services.

- Population health
- Tier 1 – services in homes, communities, marae, and schools
- Tier 2 – services in hospitals, including specialist treatment and specialist diagnostic services
- Disability services

General observations

- The emphasis is on having planning and funding driven by the community.
- Services at home and in the community would be supported by a network of hospitals "with specific roles, locally and nationally". There is an expectation that services and people will be connected through shared data systems, a more mobile and multi-disciplinary workforce, proactive outreach, telemedicine, agreed pathways and protocols, and new funding arrangements. There are possible fishhooks with some of these areas and, as resourcing will be an issue, clinicians would need to be involved in their introduction and expansion.
- DHBs will be required to target resources to particular communities. How well this works in practice will depend on DHBs having good processes and sufficient resources. It will also depend on the strength of the evidence used for developing different services.
- A positive suggestion is to pool resources with ACC for joint purchasing of national services.
- Tier 1 services will be required to accept joint responsibility with other providers for certain health and wellbeing outcomes and, over time, all public funding will become contingent on these outcomes. The problem will be deciding how the outcomes are defined, agreed, and measured, particularly when there is inherent difficulty in attributing outcomes to particular health care services, particularly those in Tier 1.

Population health

This gives a wider definition to public health.

General observations

- The emphasis on population health appears positive and long overdue.
- The recognition that funding needs to be invested strongly in population health approaches and services is positive. The Review stresses the importance of a population health approach and notes that "Improving population health must become the driver of all planning within the system".
- The Review does not propose to establish an independent Public Health Commission. As epidemiologists David Skegg, Jim Mann, and Nick Wilson have noted, the failure to create a standalone public health agency does not take into account learnings from recent public health disasters, such as the Hawke's Bay water contamination crisis, and most significantly, the findings from the COVID pandemic.

Tier 1

Tier 1 services are to include maternity, general practice and nursing services, marae-based services, district nursing, community pharmacy services, mental health services, medicines optimisation, home-based care and support, rehabilitation and palliative care, and others.

General observations

- The Review frames its discussion and proposals in terms of separate structures (Tier 1 and Tier 2) rather than taking a systems-wide approach that would integrate community and hospital services.
- It is acknowledged that services should partner across government. The Ministry of Health will be responsible for this work, though we question whether the Minister should be responsible given it would involve cross-sector cooperation, which might be better achieved at ministerial level.

- The Review advocates an approach that "emphasises prevention, the multiple determinants of health, health equity, intersectoral partnerships, and understanding needs and solutions through community outreach". ASMS's submission to the Review noted that claims for illness prevention in primary care often do not align with the evidence and argued for a systems-wide approach.
- The Review proposes that DHBs would be responsible for planning and organising all Tier 1 services. This would add significant complexity to DHBs' planning and funding functions. This includes contracting directly for services currently purchased nationally or through nationwide arrangements, such as for general practice, maternity, and Well Child / Tamariki. In the context of the proposed reduction in the number of DHBs, implementing this change will be challenging.
- The Review notes that Tier 1 is the entry point into the system, yet it is silent on the referrals process. There is also no meaningful discussion about integration between hospital and community-based care.
- Core services are to be available across all localities. However, there will be differences in the mix of services and business models, including NGOs and kaupapa Māori services. It is proposed that Health NZ would develop detailed commissioning guidance for a range of Tier 1 services, including contracting options for general practice. It will be important that Health NZ monitors DHB contracting and any variation across localities.
- Under the proposals, DHBs would no longer be required to contract primary health organisations for primary health care.
- Funding for Tier 1 services would be ring fenced. Any increase in funding for Tier 1 should not impact on the investment required for hospitals.
- The absence of a proposal to eliminate primary care user charges is disappointing. This is critical for ensuring equity of access for any level of care.

Tier 2

The Review acknowledges that services provided in Tier 2 (public and private hospitals, specialist treatment and diagnostic services) are vital and demand will continue to grow. There is a strong technology emphasis, particularly with finding new ways of delivering Tier 2 services and to enabling different models of care and different modes of working, for example, it proposes that hospital services should be delivered for extended hours and provide more virtual and outreach services. It encourages virtual care and recognises that increased virtual care services must be built into rosters. It emphasises that any service development should be clinically led.

The Review recognises that continued equity issues and the variation in access and outcome are unacceptable. It also suggests that Health NZ work alongside existing rural health providers to share innovations and best practice.

The review notes that DHB expenditure is heavily weighted towards nursing and medical personnel and expenditure on medical has increased more than other categories. It suggests that DHB deficits are directly attributable to growing demand and increasing wage levels.

General observations

- The Review acknowledges the limited investment in acute hospital capacity and the unsustainable use of emergency escalation plans for managing excess demand.
- It makes an unrealistic claim that much future demand will be managed by efficiency gains.
- It acknowledges the need for "significant investment in hospital facilities … to address capacity issues" and suggests there should be greater certainty in funding.

- It is not clear how current arrangements will allow for the greater adoption of technology. It is not clear how rosters will be able to accommodate more time for virtual care.
- There have been IT failures in the past, and it is not clear from the Review how increasing technology will improve productivity. New technology, such as robotics, is often expensive. How these will be funded and weighed up against other demands is not clear.
- The review emphasises effective-care pathways, and the sentiment of improving the quality of care is welcomed, but it is not clear how more time will be freed up to achieve this level of care.
- It proposes longer opening hours but does not specify how this will be managed so that it does not lead to further pressure doctors.
- The review has a positive focus on the performance of hospital and specialist services, but performance management data, reporting, and analysis practices must be clinically driven and not be punitive.

Disability services

Many changes are proposed for disability services. It proposes that the principles of Enabling Good Lives should drive service design so that a person's impairment is not what defines their life chances. The Review recognises the need for a skilled workforce to meet the increasing needs around disability and that it should be on secure salaried contracts and that salary rates should be consistent.

The Review proposes that most disability funding should be devolved to DHBs and managed with Tier 1 services. Work on assessing the required level of investment should be completed before being rolled into the DHB baseline and funded via the population-based funding formula. In the meantime, it recommends that contract management transfers to Health NZ.

General observations

- There will be increased pressure on DHBs' budgets from the transfer of responsibility for all disability services. Potentially then, other DHB services may lose out and disability support funds may be used for other things. While Tier 1 funding will be ring fenced, it is not clear whether disability services funding will be protected within that ring fence.
- A positive move is that Health NZ will be responsible for developing a consistent framework for disability support contracts that aligns with the Tier 1 framework. This will specify core components that must be nationally consistent, while allowing DHBs flexibility to contract their own services.
- The Review proposes that needs assessment and services coordination services should be integrated into Tier 1 service networks. There is an expectation that Tier 1 services "minimise adverse health consequences, for example, increased hospitalisations associated with disability". This approach needs be taken with great care so that people are appropriately referred when they need hospital level care.
- In summary, the changes proposed in the Review should be beneficial for people with disabilities and disability support service providers. It will be important that the changes are well-managed to ensure a smooth transition.

Changes to the workforce

The Review endorses getting the workforce right as key to improving health outcomes. It recognises workforce shortages but appears to see the (vague) answers in changing workforce roles and 'new models of care'

General observations

- ASMS agrees with much in this section but has concerns as to how the detail will be implemented and questions how the review plans to improve the specialist workforce, given current workloads, will affect future industrial negotiations.
- The team-based emphasis is positive and supported as is the recognition that the workforce needs to better reflect the people it is serving, particularly with regards to ethnicity.
- There is positive recognition of issues such as stress and workloads. Nevertheless, increasing employee control and opportunities for flexibility are strategies that are only going to work if workforce numbers are also increased and there is less pressure to work longer hours.
- The recognition that the current workforce model is not sustainable raises some questions: while the emphasis on the need for greater team work is positive, it remains to be seen whether the emphasis on "different ways of working", including a greater adoption of new technology, will resolve all issues.
- The Review recommends a legislated Health NZ charter that covers the behaviours of the health workforce. The charter would influence how care is delivered in homes, communities, and hospitals. Health NZ would develop the charter with the Ministry and the Māori Health Authority. This will need to be closely monitored.
- The emphasis in the Review for greater oversight on growing, training, and regulating the workforce is positive. The suggested creation of a workforce plan is sound and overdue. It is heartening to read reference to the need for union involvement in the development of this.
- The need for better workforce data and improved long-term planning and modelling all appear sound. The key issue here is ensuring that the data used is clinically informed.
- The Review seeks to have greater influence over workforce training. It notes that the Tertiary Education Commission should have more explicit plans to grow the health workforce. This appears positive, but it raises questions about where future medical graduates choose to specialise and the length of training they receive.
- Similarly, the Review comments on the regulatory system and how this can be improved. While much of what is noted appears positive and sensible, it is likely that there may be ramifications for the various responsible authorities and professional bodies. There is little detail in what is proposed.
- The section on strategic employment relations discusses the need for a "more professional and centralised employment relations function within Health NZ". Again, it remains to be seen what this looks like and how this will affect approaches to future MECA negotiations.
- The suggested revitalisation of the Health Sector Relationship Agreement appears sound and is welcomed. However, the statement that the sector needs to grow the ability to see "change as the norm and not a threat" raises questions about what lies ahead. While the general rhetoric appears sound, the issues will arise in the detail.

Introduction of digital and data processes

A key proposal is that digital systems in both Tier 1 and Tier 2 should support more delivery of virtual care and this should be prioritised to serve communities that have issues with access, such as rural communities. The Review envisages that "provider job descriptions, scopes of practice, performance

metrics, codes of practice would need to be recalibrated to support the increasing use of telehealth … it would require collaborative re-design of service provision and subsequent change management for providers and consumers."

Health NZ will be responsible for digital technology, such as developing and implementing a long-term digital plan.

The Māori Health Authority are to take a leadership role in ensuring Māori data sovereignty, providing Māori population health analysis and analytics, and ensuring that the digital plan addresses equity issues for Māori.

The Review emphasises that consumers are to be able to control and access their own health data and information.

Priority for digital investment will be given to initiatives that will accelerate interoperability between Tier 1 services (given their importance for improving equity).

The Review acknowledges that investment is urgently required for upgrading or replacing different systems in current use, and funding is required for system-wide leadership and workforce development over the next three to five years.

It proposes there be a digital applications and asset management plan and a long-term investment plan and that the capital decision-making processes for digital and facilities should be integrated.

General observations

- ASMS believes it is essential that increasing virtual care services are clinically-led and not driven solely by IT.
- The Review supports better data and the use of digital solutions to free up clinician time. We note that many SMOs are under considerable workload and time pressures and do not have time for current non-clinical duties. This added expectation could add to stress levels.

Changes to how facilities and equipment are managed

Health NZ (through the Health Infrastructure Unit [HIU]) will be responsible for developing the long-term investment plan for facilities, major equipment, and digital technology. The HIU has four functions: national asset management planning and prioritising capital funding; monitoring capital projects; developing national design standards for hospital facilities; and managing the delivery of major projects and providing support to DHBs to deliver projects.

Health NZ is to develop a prioritised nationally significant investment pipeline and to consult with the Capital Investment Committee (CIC).

The CIC will continue to provide independent advice to Ministers on business case approvals.

Each DHB will have a longer-term rolling prioritised capital plan for the medium-term and longer-term service requirements. As this will reflect the merged DHBs, they will be sizeable plans.

General observations

- The Review says there needs to be more transparent planning and better governance. This sounds good, but the proposals (especially for investment management decision making) may undermine this objective.

- The Review makes no recommendation to abolish the Capital Charge, which in our view should be a priority. DHBs are required to pay back 6 percent of the cost of any government capital investment in the form of a capital charge each year. It was first introduced in the 1990s to emulate market forces within government and create a level playing field with the private sector as part of the aim to create a competitive marketplace in health. The charge has become, at best, a money-go-round (an unnecessary administration cost) and at worst is being used as a penalty for DHBs that are not able to stay within an inadequate budget. There is no good case for its existence, especially if capital assets are to become more centrally planned and managed.
- There is an assumption that standardised design for hospitals is cheaper and leads to better design outcomes. No evidence or examples are provided.
- The Review says that the proposed process for business case approval will mean more timely decisions, although it seems quite convoluted involving the Health NZ Board, the HIU, CIC, and the DHBs. Health NZ Board will be made up of DHB members.
- There will be more financial and governance expertise on DHB boards, together with system and district accountability. This should ensure better long-term asset management decision making, but much will depend on the calibre of appointments. It is not clear what district accountability there will be?