

CABINET SOCIAL POLICY COMMITTEE: IMPROVING THE HEALTH SYSTEM: FURTHER ELEMENTS

Paper Eight B: A sustainable health and disability system – locating services at the right level, and funding and dispute resolution to support collaboration

PROPOSAL

1. This paper proposes a clear set of principles for deciding whether national, regional, or local is the best location for service planning. It also proposes flexible funding approaches to provide stronger incentives for performance to providers and to remove barriers to innovation, and a clear dispute resolution process.
2. Companion paper 8A proposes content, form and process for national, regional and district plans together with the implications for effective accountability. It also proposes improved and streamlined planning and accountability arrangements;
3. Together, the proposals in the two papers will support decisions being made at the right level of the health and disability system and improve collaboration amongst District Health Boards (DHBs) through regional service plans, with performance measures aligned with clear and strong accountabilities. This will improve performance, enhance the clinical and financial sustainability of services and reduce bureaucracy.

BACKGROUND

4. Cabinet's previous decisions are set out in companion paper 8A.

COMMENT

Locating services at the right level in the system

5. A strong theme of the changes that we have made to the health and disability support system has been that decisions should be made at the appropriate level of the system. Cabinet has requested further information on the location of planning, funding and accountability.
6. Currently some services struggle to be viable at the district level. A recent example is the obstetrics and gynaecology service in Whanganui where ongoing difficulties recruiting and retaining staff for a standalone service and isolated practice led to continuing concerns over coverage and safety. Such services would be more clinically or financially sustainable if planned collaboratively or even nationally.
7. Similarly, there are services being planned and funded nationally that would be more effective if integrated with DHB responsibilities, for example, Nicotine Replacement Therapy that could be managed as part of the community pharmaceutical budget.

Decision Making Principles

8. To help address these problems, I propose that the following principle is used to guide decisions on the location of service planning, funding and provision.
9. Services should be planned, funded and provided around the size of the population (national, regional or district) best able to ensure the future clinical and financial viability of a safe, quality public health and disability service; starting with those services currently most vulnerable to service disruption due to, for example, lack of suitable permanent workforce of sufficient size. In giving effect to this organising principle the following factors should be taken into account: that is, the need to:
 - provide a unified service with effective service integration across all providers, especially community, primary and secondary;

- make best use of workforce and capital, planning and funding capability and to minimise administrative and contracting overhead;
- minimise risk and disruption and provide for longer-term service continuity; and
- be responsive to distinctive local needs.

New National Services

10. Using this guide the National Health Board Business Unit, monitored by the National Health Board, will advise me on services where patient care, access, and clinical and financial viability can be improved by national involvement.
11. That involvement may be planning and funding, planning only, or a national led service improvement programme. The National Health Board may also advise that a national clinical network may be needed to improve decision-making and drive action through greater clinical leadership and engagement.
12. The National Health Board Business Unit has recommended a small number of services that should begin to transition to National Service status in 2010/11. They have taken advice from the National Health Board who are in agreement and consider that centralising the planning of these services will address the needs of the most immediately vulnerable services. The services are: clinical genetics; a number of paediatric sub-specialties; neurosurgery; and pre-implantation genetic diagnosis.

Regional and district services

13. I also propose that DHBs work together in regions, and use the principles above to identify the services they will collaborate on. Collaboration allows efficient use of planning skills, and the resulting services address professional isolation and use resources more efficiently in serving a larger population base. All other services will have their implementation planned at district level. These decisions will be reflected in the service coverage schedules that form part of the Crown Funding Agreements with DHBs.
14. I am also keen to get action on services that would benefit from greater collaboration but that have previously proven challenging for DHBs to tackle. For this reason, I am asking the National Health Board Business Unit, monitored by the National Health Board, to work with DHBs to get early agreement on which services may need to be planned collaboratively. The National Health Board will make government priorities clear. I expect the process to be conducted in accord with the requirements I have proposed around public consultation (refer to paper 8A).
15. This approach places accountability with DHBs but ensures that DHB tackle previously challenging service issues, and will help ensure that national and regional action is appropriately integrated. The National Health Board's assistance will also be helpful in overcoming barriers to collaboration; for example through dispute resolution.

Funding to improve service performance

16. In October 2009 Cabinet¹ directed the Ministry of Health to report to SOC on non-legislative mechanisms to support DHBs to progress further and faster on collaborative planning, including through possible changes to funding.
17. I propose an increased role for the National Health Board Business Unit, monitored by the National Health Board, in driving the use of improved means of funding to achieve better service performance. I also intend to approve plans only if they contain effective methods of funding.
18. While the current bulk funding of DHBs has advantages, it provides only weak incentives to improve the efficiency, quality, and volume of services provided. In particular,

¹ CBC Min (10) 2/2 26

- Efficiency incentives are undermined by the ability to run deficits for a protracted period, even after prolonged growth in funding
 - Governments have had to supplement DHBs' funding to try to secure increased volumes in high priority area, like electives
 - Service quality is not recognised and the MRG report noted that DHBs have very mixed incentives to improve service quality
19. Moreover, in some areas funding is tightly matched to specific inputs which does not reward results or allow flexibility to substitute between inputs when that would result in a better outcome. We are addressing this issue in Whanau Ora and as part of our response to the 2008 Social Service Committee's Inquiry into Disability Services.
20. There is a need to improve the way funding is used to drive improved performance. We need to shift, where appropriate, to funding the outcomes people want and giving greater freedom to providers to be innovative in delivering those outcomes, within the resources available. We need to fund services in a way that encourages providers to provide more and higher quality care to more people for each dollar spent. For example:
- The way funding has been managed for elective surgery has seen a dramatic upturn in volumes after years of stagnation;
 - Additional payments can be used to incentivise the attainment of immunisation targets
 - A higher price for screening providers to screen those we are not good at reaching may result in better coverage for those most likely to benefit from screening;
 - The approach to setting subsidies and tendering used by Pharmac has been successful in constraining the cost of community pharmaceuticals. At the same time DHBs have retained the budget for community pharmaceuticals and have an incentive to influence prescribing behaviour;
 - The alliance contracting approach that we are trialling in primary care aims to remove barriers to innovation;
 - Budget holding, such as for referred tests in primary care. This is an example of arrangements that place risk with those best placed to manage it. The arrangements have powerful incentives. It is however important to design these arrangements in a way that appropriately shares the benefits accruing from these incentives.
21. The funding method best for a particular service depends on what we are trying to achieve for the service, so I do not wish to move to a one-size-fits-all approach. It is, though, important that the sector is much more innovative with its methods of funding and that much greater attention is given to the performance gains that good choice of funding methods can support.
22. I expect the National Health Board Business Unit to advise me on changes needed to the funding of national services to meet these objectives. I am also proposing a central role for them in encouraging and supporting DHBs to be more innovative in the application of their allocated funding at regional and district levels. I will expect them to work closely with the National Health Board.
23. The elements of the funding system I propose are, therefore:
- Funding will continue to be allocated to all DHBs in accord with the Population-based Funding Formula although we will also progressively work deficits out of the system. DHBs will use this funding to provide or purchase district and regional services for their populations;
 - The way in which each DHB will pay its share of the costs of a collaborative service and the way in which they will collectively pay the provider of the service will be negotiated as part of the regional plan. This is where I expect more innovation;
 - The National Health Board Business Unit, monitored and advised by the National Health Board, will play a strong support role in helping DHBs to identify appropriate funding

methods and price structures and levels, particularly through the provision of relevant costing information and economic advice;

- Importantly, the Minister of Health's acceptance criteria for plans will mean that plans will only be approved if the funding mechanisms in them are effective at achieving the aims of planning the service collaboratively or nationally;
- The risk of disagreements between DHBs and consequent delays in finalising and implementing plans will be managed through a firm dispute resolution process.

24. Changes to methods of funding services that have significant impact or affect government policy or legislation will continue to come to me for decision and, as appropriate, to Cabinet.

Dispute resolution

25. The degree of collaboration required by the Government's changes to the health and disability sector will present DHBs with many challenges and a clear and time-limited dispute mechanism will be helpful for resolving impasses.

26. In January 2010, Cabinet agreed to amend the NZPHD Act to strengthen dispute resolution provisions by, in a new Section 39, empowering the Minister of Health to resolve disputes between DHBs over the contents of a plan. The amendment also allowed regulations to be made, under section 92(2), to govern wider dispute resolution processes without needing the agreement of the affected parties. Such disputes may concern the implementation of a plan or the provision of shared administrative and support services or joint procurement.

27. I propose that regulations apply to **any** disputes between DHBs and / or other publicly-owned health and disability organisations. However, I consider that disputes involving other (private) parties would be better resolved through non-regulatory approaches, such as contractual mechanisms.

28. Cabinet also directed² the Ministry of Health to develop a clear and transparent framework that sets out the circumstances under which intervention in disputes should take place.

29. Many dispute resolution procedures contain a series of steps to enable parties to resolve disputes quickly and cheaply without the need to resort to formal processes. Such an approach fits well with my intention that DHBs will endeavour to resolve disagreements amongst themselves, with regulatory intervention taking place only where there are material risks to the clinical and financial sustainability of the health and disability system. Disagreements that threaten the timely preparation or implementation of plans would be such a case.

30. I propose that the regulated dispute resolution process, under section 92(2), would be triggered by a DHB involved in a dispute, or the Minister on becoming aware of a disagreement between the DHBs.

31. The first step in dealing with disputes is to avoid them arising. DHBs may choose to use an independent Chair or a clinical network to assist them in collaborating.

32. In the event of a dispute between DHBs, which they cannot resolve between themselves, assisted negotiation or mediation will be the next step. While the mediation process should be left to the parties to agree where possible, the following issues will need regulation to ensure timeliness:

- *Entering mediation:* Mediation may be initiated by either party to the dispute or by the Minister;
- *Choice of mediator:* A third party nominates a mediator if the parties to the dispute cannot agree on one within 10 days. This should be the President of the NZ Arbitrators and Mediators Society;

² CBC Min (10) 2/2 refers

- *Completing mediation in a timely way:* The time allowed for mediation to run its course will be limited to 30 days. If agreement is not reached in this time, the process moves automatically to arbitration.
33. The final step is binding arbitration. Regulation will lay out the process in some detail. The proposed regulation will establish the Director-General of Health as arbitrator. The purpose of this is to avoid a large range of disputes being escalated to the Minister of Health. The role of the Minister here will be to set the objectives for the dispute resolution process (to be included in the regulations – see paragraph 34) and, if the arbitration is challenged, to review that the process was followed and the objectives met.
34. I propose that the Director-General of Health first establishes an advisory panel, with at least three members, to provide advice on the dispute before a determination is made. The Chair of the National Health Board will nominate suitable members either from within the Board, or from elsewhere if it is necessary to get other expertise or avoid conflicts of interest. The main elements of arbitration requiring regulation are:
- *Advisory panel:* Regulations will guide the selection of panel members, to ensure that the choice does not compromise the objectives of the dispute resolution process or its outcomes. For example: the Director-General shall appoint the panel members, from the nominations from the Chair of the National Health Board, ensuring there is the expertise needed (for example, clinical or economic); members of the panel shall notify the Director-General and the parties to the dispute of any potential conflict of interest;
 - *The process the advisory panel is to follow:* I propose the regulations include: the Government's objectives that will guide the panel's analysis; the objectives of the dispute resolution process; the need to respect confidentiality; and the information that the panel must or may use in reaching its conclusions, including the views of relevant stakeholders and specialist clinical or economic advice;
 - *Determination:* The Director-General will make a determination on the dispute, following the provision of the advisory panel's advice and that decision will be final. The Director-General may seek additional advice if he/she wishes. There will remain a right of appeal on grounds of due process, through judicial review. I propose that the Director-General of Health may also determine costs, namely how remuneration, traveling allowances and expenses for the advisory panel and other costs of the process are to be met (the parties to the dispute would meet their own costs of participating in the process);
 - *Publication of findings:* I propose that the advice of the advisory panel will be published to ensure transparency.
35. Having the Director-General make the determination under these regulations differs from the case of dispute resolution for the contents of a plan under section 39, where the Minister makes the determination. However the Minister of Health may choose to delegate³ the determination of a dispute under section 39 to the Director-General of Health.

Ministry of Health reorganisation

36. The changes in these papers have implications for the skills within the National Health Board Business Unit established in November 2009 following Cabinet decisions in October 2009. The Ministry of Health is currently reorganising to support the work arising from the Government's changes to the health and disability sector and appropriately resource the Business Unit, and work in a more streamlined and efficient way. Further information on the functions of the Business Unit and the reorganisation of the Ministry of Health will be provided to Cabinet in a further report⁴ as directed by Cabinet in October.

³ Power to delegate is covered by section 28 of the State Sector Act

⁴ As required by CAB Min (09) 37/13-15, 52

CONSULTATION

37. The following have been consulted: The Treasury; the State Services Commission. The Department of the Prime Minister and Cabinet has been informed.
38. The Chair of the National Health Board has been consulted and his views are reflected in the paper.

FINANCIAL IMPLICATIONS

39. The costs of dispute resolution (remuneration, travelling allowances and expenses for the advisory panel and any other costs) are to be met from Ministry of Health Departmental Expenditure within existing Vote Health baselines.
40. There are no other financial implications arising directly from the recommendations in this paper. Better choice and use of funding mechanisms will lead to higher performance, improved sustainability, and higher efficiency of services. Financial considerations such as improved efficiency through better integration with supporting services or reduction in overhead will be an important criterion in locating services at the right level of the system.

HUMAN RIGHTS AND GENDER IMPLICATIONS

41. There are no human rights or gender implications arising from this paper.

DISABILITY PERSPECTIVE

42. There are no specific implications for people with disabilities associated with this proposal.

LEGAL IMPLICATIONS

43. The NZPHD Amendment Bill has been introduced. Once enacted it will allow regulations to be made to implement the proposals in the paper.

REGULATORY IMPACT ANALYSIS

Regulatory Impact Analysis requirements

44. The Regulatory Impact Analysis requirements apply to this paper. A Regulatory Impact Statement (RIS) has been prepared, and is attached to this Cabinet paper.

Quality of the Impact Analysis

45. The Ministry of Health's Internal Cabinet Paper Committee has reviewed the RIS prepared by the Ministry of Health, and considers that the information and analysis summarised in the RIS meets quality assurance criteria. While the RIS is long, this is necessary to adequately cover the technical issues under consideration, and the RIS is clearly written.

Consistency with Government Statement on Regulation

46. I have considered the analysis and advice of my officials, as summarised in the attached RIS and I am satisfied that, aside from the risks, uncertainties and caveats already noted in this Cabinet paper, the regulatory proposals recommended in this paper:
- are required in the public interest;
 - will deliver the highest net benefits of the practical options available;
 - are consistent with the commitments in the Government Statement on Regulation.

COMMUNICATIONS / PUBLICITY

47. There will be a period of public consultation as part of the legislative amendment process.

RECOMMENDATIONS

It is recommended that Social Policy Committee:

1. note that, on 19 October 2009 and 26 January 2010, the Cabinet Business Committee made decisions on improving the health system and directed the Ministry of Health to report to SOC on proposals for planning and dispute resolution regulations as well as non legislative mechanisms to support improved collaboration across the health and disability system [CAB Min (09) 37/13-15 and CAB Min (10) 2/2 refers];
2. note that Cabinet agreed that the Minister of Health will determine, in consultation with the health sector, what health services should be planned and funded at the national level, and provide guidance as to what services should be planned and funded at regional and local levels by DHBs [CAB Min (09) 37/13-15];

New national services

3. note that the National Health Board Business Unit, monitored by the National Health Board, will provide the Minister of Health with advice on services that will be nationally planned and funded or be the focus of centrally coordinated performance improvement activities;
4. note that I have received proposals for a small number of highly specialised or vulnerable services that will begin a transition to a national planning level in 2010/11;

Regional and district services

5. agree that DHBs, working together in regions, will identify the services they will collaborate on to plan and implement, while all other services will have their implementation planned at the district level;
6. note that I have requested the National Health Board Business Unit, monitored by the National Health Board, to facilitate a process with DHBs to get early agreement on which services should be planned collaboratively;

Funding

7. note that on 26 January Cabinet directed the Ministry of Health to report to SOC on non-legislative mechanisms to support DHBs to progress further and faster on collaborative planning through possible changes to funding mechanisms;
8. note that I propose a flexible approach whereby the funding method that best supports the achievement of service objectives is selected when the service is being planned;
9. agree that the National Health Board Business Unit, monitored by the National Health Board, will provide much greater support for and scrutiny of funding and purchasing methods proposed in national and regional service plans in order to improve the effectiveness of proposals;
10. note that plans will only be approved if the funding mechanisms in them are effective at achieving the aims of planning the services collaboratively or nationally;
11. note that changes to methods of funding services that have significant impact or affect government policy or legislation will continue to come to me for decision and, as appropriate, to Cabinet;

Dispute resolution

12. note that on 26 January 2010 Cabinet agreed that section 92, clause 2, of the Act be amended to allow regulations to determine rules governing dispute resolution processes, without needing the agreement of the affected parties;
13. note that on 26 January 2010 Cabinet directed the Ministry of Health to develop a clear and transparent framework that sets out the circumstances under which intervention in disputes should take place, including through delegating the responsibility for advice on dispute resolution and intervention to the National Health Board;
14. note that disputes over the content of a regional service plan may arise where DHBs are unable to agree on the difficult and necessary decisions needed to safeguard the sustainability of the health system;
15. agree that a regulated dispute resolution process can be triggered for such disputes by either a participating DHB or by the Minister;
16. agree to a stepped approach of mediation followed (if necessary) by arbitration;
17. agree that mediation is regulated so:
 - 17.1. mediation may be initiated by either party to the dispute or by the Minister;
 - 17.2. the President of the NZ Arbitrators and Mediators Society nominates a mediator if the parties to the dispute cannot agree on one within 10 days;
 - 17.3. the time allowed for mediation to run its course will be limited to 30 days. If agreement is not reached in this time, the process moves automatically to arbitration;
18. agree that arbitration is regulated in more detail, setting out:
 - 18.1. considerations in the appointment of the advisory panel, including the need for appropriate expertise and declaration of potential conflicts of interest;
 - 18.2. the process the advisory panel is to follow, including: being guided by the Government's objectives; the objectives of the dispute resolution process; the need to respect confidentiality; the information that the panel must or may use including obtaining specialist clinical or economic advice and seeking the views of stakeholders;
 - 18.3. that the advice of the advisory panel will be published;
 - 18.4. that the Director-General of Health makes the determination following advice from the advisory panel and may determine how costs of the advisory panel are to be met;
19. note that the Chair of the National Health Board will nominate suitable members for the advisory panel, either from within the Board, or from elsewhere if it is necessary to get other expertise or avoid conflicts of interest;
20. agree that any disputes between DHBs and / or other publicly-owned health and disability organisations may be resolved through the regulated process;
21. invite the Minister of Health to arrange the issue of drafting instructions for dispute resolution regulations to the Parliamentary Counsel Office to give effect to Cabinet decisions on this paper.

**Hon Tony Ryall
Minister of Health**

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